State of Maryland / Department of Health and Mental Hygiene 0 0 5

	Registrar	epartment of Health and Mental Hyg Certificate of Death	eg. No.
Physician /Medical	Edita Hay Billi BB1	2. Date of Deat SEPT	th Day 01 2005 0638 Am
Examiner	4a. Facility Name (If not institution, give street and number) Washington County Hospital	4b. City, Town, or Location of Death Hagerstown	4c. County of Death Washington
Funeral Director	5. Social Security Number 214-09-5139 6. Sex 1 □ M 2 ▼ F 7. Age (In yrs. last birthe 91 Yr	Months Days Hours Min (Month Day	7,1914 9. Birthplace (State or Foreign Country) Maryland
death with the Maryland rms 23a or 28a-f show rmust be notified at	10a. State 10b. County 10c. City, Town of	Hagerstown	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
uth with the 23a or 2 ust be no		10f. Zip Code 21740	0g. Citizen of What Country? USA
036 urs after sir, or ite	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:	14. Race - American Indian, Black, White, etc. Specify: white
21215-00 ed within 72 hor ygiene. "natura ist than "natura it, the Medical Et.	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 16a. D (6) (6) (7) (7) (8) (8) (1) (8) (9) (1) (9) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1	ecedent's Usual Occupation Give kind of work done during most of working fe. DO NOT use retired) memaker	16b. Kind of Business/Industry her own home
yland 2 Vland be filed Mental Hyg arked other attic event, I	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Mollie Loud	Maiden Sumame)
Mary nd 2 shou slith and M 27 is mar	19a. Informant's Name/Relationship (Type, Print)	dailing Address (Street and Number or Rural Route Number, 030 Salem Avenue, Hagerstow	City or Town, State, Zip Code)
more, Pages 1 ar	20a. Method of Disposition 1 S Burial 2 ☐ Cremation 3 ☐ Removal from State	isposition (Name of Date 2 crematory or other place)	20c. Location - City or Town, State Williamsport, Md.
Balti permit. Departm importa any inju	21. Signature of Puneral Service Licensee	The state of the s	FUNERAL HOME
/ Inysician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	enter the mode of dying, such as cardiac or respiratory arre	Approximate Interval Between Onset and Death
MCLL SMIPLEY I Records, P.O. Box 68760, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examir	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 Ectopic pregnancy 5 Other (specify)	23d. Date of delivery Month Day Year
cords, P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I. 23e. Did tobi	acco use contribute to the cause of death?
al Record The law requir The law requir That a been si That a been si That a been si		24a. Was an autopsy perform	prior to completion of cause of death?
Division of Vital Rec Hospital or Attending Physician: The lav 4 hours after death. Funeral Director: After this certificate has tely filled in by the funeral director, page 2	25. Was case referred to medical examiner? 1	e of 28c. Injury at 28d. Describe hov	nce 6 Other (Specify)
Divisor and urs after dural Direct lled in by the Certific		City or Town,	
Div To the Hospital or, within 24 hours after To the Funeral Dire completely filled in Medical Certii	one) 2 Medical Examiner: On the basis of examination and/o		te and place, and due to the cause(s)
or sign of sig	29b. Signature and title of certifier	D48940	d. Date signed (Month, Day, Year)
SH-4	30. Name and address of person who completed cause of death (Item 23a) (Ty, W. E. W. Zera, M.D. 747 W. Harra 31. Date filed (Month, Day, Year) 32. Registrar's Signature	pe, Print) Hagerstown MO	31742
State Registrar	31. Date filed (Month, Day, Year) SFP 0 2 2005	Snaule	

rn			1 - For Unpend Item Registra MEND#24a/bp	State of 23a,27,2 erverbalME,9	Marylan 8a-f p /8/05,E	d/Depa er me W,MC <i>ei</i>	rtment of 1847 9- Tificate o	Health 18-05 f Deat	n and M tas th	lental Hy	giene Reg. No.	2005	30002
п	Dhysia		Decedent's Name (First, Middle,	Last)						2. Date of De	ath		3. Time of Death
	Physici /Medi		Keith Lloyd Scribne	er						Septemb	er 0	6, 2005	8:20 P M
	Examir		4a. Facility Name (If not institution,	give street and numb	oer)		4b. City, Town	, or Location	on of Death		4c.	County of Death	h
			198 Halpine Roa	d. Apartme	nt 116	51	Rocky	ille.				Montgome	ρ r v
0	Funeral		5. Social Security Number	6. Sex 1 7.	Age (In yrs.		If Under 1 Ye	ar If Und	der 24 Hrs.	8. Date of Bi	rth	9. Birth	nplace (State or Foreign untry)
7	Director		216-64-0567	1 3t M 2 ☐ F	44	Yrs.				Oct. 7,			York
ر	pu 🔭		Usual Residence of Decedent 10a. State 10b. County		10c Cib	y, Town or Lo	ontion						404 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	anyla	'n			100.00	y, TOWN OF EC	Cation						10d. Inside City Limits 1 Yes 2 □ No
	98-f	ectc	Virginia		Cha	rlottes							
	vith u	ä	10e. Street and Number	7			10f. Zip Code				10g. Citiz	zen of What Cou	untry?
	death with the Maryland me 23s or 28s-f show rintst te rydiffed at	Funeral Director	49 Martin Kings Ro				229					USA	
	er de	nu	11. Marital Status	12. Was Deced Armed Force	es?	S. 13.	Was Decedent of f Yes, specify C	of Hispanic (uban, Mexic	Origin? (Spi can, Puerto	ecify Yes or No Rican, etc.))- 1	 Race - Amer Black, White 	
36	hours after tural', or ite	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	-		1 ☐ Yes 2 ☐M	lo Speci	eify:			Specify: Whit	te
21215-0036	hour tural	Ď.	15. Decedent's	Year or Date	98.	160 Dans	tentia Haval Oss				1.51 16		
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12	within ene. then	Ĕ	Elementary/Secondary (0-12)	College (1-4	or 5+)			,					
	filed Hygir ther		17. Father's Name (First, Middle, L.	<u> </u>		Reg.	istered Ni	7	other's Name	(First, Middle		th Care	
Maryland	ntal d o	Be	Lloyd H. Scribner	,							, maiderr	obmanie)	
2	d Me	ဥ	19a. Informant's Name/Relationshi	o (Type Reint)		10h Mailie	- Address (Chie		rjorie		0	T 0: - 7	
Ma	12 s h an 7 ia i		Lloyd H. Scribner									Town, State, Zi	ip Code)
	1 and Healt	-	20a. Method of Disposition	/ radier	20h P		commander sition (Name of		7	SVIIIe, I			C
ŏ	S T T T		1 ☐ Burial 2 ☑ Cremation	3 □Removal from St	ate C	emetery, crer	natory or other p	olace)	Septer	iber 8	20C. LO	cation - City or T	own, State
ij	tant dung		4 Donation 5 Other (Spe		Meta		n Cremato		200			ndria, Vi	rginia
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. important: if Itam 27 ia marked other than "natural", or iteme 23a or 28e-f ahow any injury-cro		21. Signature of Funeral Service Li	censee .	2	F1 50	Name and Add ancis J O Univers	Collin Sity Bl	cility ns Funei Lvd, W.,	ral Home Silver	Inc Sprin	g, MD 209	001
			23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final	omplications that cau nly one cause on eac	ised the death th line.	n. Do not ent	er the mode of d	lying, such a	as cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Fentan Fentan			ion						
	Examiner			Due to (or	as a consequ	uence of):							
		-	Sequentially list conditions, if any, leading to immediate	b. — Due to (or	as a consequ	ience of):							
	ted	n i	Cause (Disease or injury			201100 017.							
	xecu al-tra	хаг	that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):							
68760,	ficate be executed physician and s the burial-transit	edical Examiner											
587	ficate phy: s the	윷		d									
			IF FEMALE:	23c. If yes, outco	me of pregna	nev							
Вох	eath atter for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt	h 2 ☐ Fetal	death 3	Ectopic pregnar Other (specify)				2	3d. Date of deliv Month	very Day Year ;
Ö	the d	Physician/M	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknow		3E.	Cities (specify)						
P.0	law requires that the death certi as been signed by the attending 2 should be detached for use a		Part II. Other significant condition	s contributing to deal	th but not resu	ulting in the ur	deriving cause i	given in Par	rt I.	23e, Did t	obacco us	se contribute to t	the cause of death?
of Vital Records,	sign d be	d by									Yes 2		bably 4 Unknown
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=	: The cate his	S								X Yes	rmed? 2□ No	death? X □Yes	2 □ No
Zita Zita	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	(terrial)					ace of Death	Check only	one)		
£	Physician: this certific	유	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inp		ER/Outpatien	1 3LI DON					Other (Speci	
2	ding Physician: The Ih. A. After this certificate he funeral director, page	Certification:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of	Injury Day Year)	28b. Time of 7:45	28c. In W			28d. Describe	now injury	occurred	unk
Division	tend leath tor: /	cati	2 Accident investiga	found	- 13	tound	P	∏Yes 2					
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	rs al		/	found	at hor	ne			1/1	101 KO	ckvil	le, Mar	yland
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	edicai	Check only 2A Medical E	Physician: To the be kaminer: On the basi	is of examinat	wledge, death ion and/or inv	occurred at the	time, date a	and place, a	and due to the	cause(s) a	and manner as s	stated. to the cause(s)
	thin 2 the mptel	Med		and manne	r stated.								
N.		-	29b. Signature and title of certifier	1011-				nse numbe				signed (Month,	
	12		Throphe.	M. Key	Som			O.C.M.	• L •		septe	ember 07	, 2005
				no completed cause	eath (Item	23a) (Type, I	Print)			-			
			THE DOOM MI					et, Ba	altimo	re, Ma	rylan	nd 21201	
	Sta	le	31. Date filed (Month, Day, Year) SEP 0 8 2	005 Reg	istrar's Signat	ure fac	Res .						
	Registr	ar I	JEP UO Z	AND TOTAL		100	19.00						

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Joseph Pershing Smith **Physician** Aug. 23 2005 4:15 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chestertown Nursing & Rehab. Center Chestertown 8. Date of Birth (Month, Day, Yea ~+ 18 Kent If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Year) 1XM 2□ F Months Days Hours Min NJ 86 138-10-1283 Director Usual Residence of Decedent 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at MD Queen Anne's Church Hill Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 Main Street 21623 USA Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Be Completed by Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 12 should be filed w h and Mental Hygier 7 is markad other th Machinist Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Paul Smith Mae O'Neill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: if Itam 27 is. Loie E. Smith/Wife 106 Main Street Church Hill, MD 21623 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. ö ^¹ 4 □ Donation 5 □ Other (Specify) Chesapeake Cremation 8/24/2005 Chester, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home
130 Speer RD Chestertown, MD 21620 ra Fella . / rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alzheimers dementia /Medical Due to (or as a consequence of): Examiner MALIGNANT GASTRIC LUMPHOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be axecuted use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 4☐Pregnant at time of death 5 Other (specify) signed by the a ld be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2□ No 1 ☐ Yes 2 2 No 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending after death. Diractor: Af 1 ☐ Yes 2 ☐ No М 2 Accident investigation 3 🖺 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) elakoa H0062423 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) de la Kosa DO 6602 Church Hill RD Chestertown, MD 21620 31. Date filed (Month, Day, Year) 32. Regetrar's Signature State AUG 2 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 26 Elsie Marie Sheeler /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Calvert Manor Healthcare Center Rising Sun Cecil If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K 1 F 170-07-6286 Director 91 March 28, 1914 Pennsylvania Usual Residence of Decedent 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or flems 23a or 28a-f show treumetic event, the Medical Exercities south by notified at 1 ☐ Yes 2 No Completed by Funeral Director MD Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1881 Telegraph Road 21911 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify: White Specify 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hazel Hicks John Trythall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ent; If item 27 is s Jay T. Sheeler/Step-son 656 Clifton Drive. Bear. DE 19701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Warwick Twp. 1 X Burial 2 □ Cremation 3 □ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) any injury once. 08-30-2005 Chester County, PA Pine Swamp Cemeteru 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1111 S. Queen Street, Rising Sun, Mi 23 Part1. Ent 3 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA - ALZHEIMER'S TYPE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last ed by the attending physician and detached for use as the burial-trai Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 □ No 1 Yes 2**X** No 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Certification: To 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 9 29c. License number H58419 AUGUST 27, 2005

1-

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Registrar

1881 TELEGRAPH ROSID

RISING SUN, MD

21911

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2005

DarHAM, DO

31. Date filed (Month, Day, Year) AUG 2

		State of Maryland / Dep	artment of Health and Me	ental Hygien	1e 0 0 0 m	
	_		ertificate of Death	Reg. N	/11115	30005
Physiciar		1. Decedent's Name (First, Middle, Last) MiGQie Mae.	\circ		Day A 2005	3. Time of Death 2011 M
/Medica Examine		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		Dorchester General Hospital	If Under 1 Year If Under 24 Hrs. 8	2	Dorches	ster
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) $18-86-8172$ 1 \square M 2 \square 7. Age (In yrs. last birthda) Yrs.		B. Date of Birth (Month, Day, Yea May I. I	9. Birthplac Country	. A
and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I		7 7	,	. Inside City Limits
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A Sign High High Miles High Miles High High Miles High	runeral Director	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country	?
de ath w	erai	6 2 5 - Robbins Street 11. Marital Status 12. Was Decodent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric	ifv Yes or No-	14. Race - American	Indian,
		1 More Married 2 Married 1 ☐ Yes 2 More	If Yes, specify Cuban, Mexican, Puerto Ric	can, etc.)	Black, White, etc	.
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ylanc ylanc ould be fi Mental H arked ot attc aver	o ne	Lester Shaw	18. Mother's Name (I		1	Sala
Maryland Mar			ling Address (Street and Number or Rural F		V	
he he he		Maggie 5haw 70 20a. Method of Disposition 20b. Place of Disp		bridge/	Mary Inn	21613
MOF		1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Commetery, critical commeters, critical c	ematory or other place)	105 0	cocation - sity of rown	1, 31410
Baltimore, permit. Pages 1 at Department of Hea important: if tem any injury or othe	1	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Henry Funeral He	Me P. A	imbri ege	, 1010.
0 28 5 6 8		Jerrelle - Klevry	5 10 washington S	St. Camb	bridge, M	D.21613
		23a. Part. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final	iter the mode of dying, such as cardiac or r	respiratory arrest,	In	pproximate Iterval Between Inset and Death
Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	WITH Kespister	freewo		14 Ws
Examiner		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequent of):	AIDS			5 y-25
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8760, ate be executed hysician and the burial-transit		resulting in death) Last C. Due to (or as a consequence of):				
\$8760 cate be can physician site buri	dicai	d				
Box 68 eath certifica attending ph	an/med	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3			23d. Date of delivery	
Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transitional by Dhustisian Medical Exemp	ರ		☐Ectopic pregnancy ☐ Other (specify)		Month Da	ay Year
18, P.O. res that the de igned by the abe detached	/ Fnysi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the o	cause of death?
cords w requires been sign	ed by	Poly substance Abuse		1 🗆 Yes	2 □ No 3 □ Probabl	ly 4 Hinknown
Recor	Completed			24a. Was an autopsy	24b. Were autopsy prior to compl	/ findings available letion of cause of
		CS. Was area related to marked		performed?		No
Z Z Z Z	o ne	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (Control 3 DOA Other: 4 Nursing Home		6 □Other (Specify)	
- 0 t = -		27. Manner of Death Value 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at 28c Work?	d. Describe how inj		
Division or Attending after death. Director: After line by the tune	eruncation;	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s	M 1 Yes 2 No	f. Location (Street a	and Number or Rural R	oute Number.
DIVISI DIVISI ppital or Attan ours after deal neral Director: filled in by the	Ceu	4 ☐ Homicide determined building, etc. (Specify)	,,	City or Town, Sta		,
	edicai	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, deal and manner stated.	th occurred at the time, date and place, and nvestigation, in my opinion, death occurred	d due to the cause(at the time, date ar	s) and manner as state nd place, and due to th	ed. e cause(s)
To the within 5	ğ	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day	y. Year)
		Mpoffeelew wes	D26388	Au	4 25, 2	-005
		30. Name and address of person who completed cause of death (Item 23a) (Type Michael PArtlalew Michael 34	32 Calline Hust	ock mil	721643	
State		31 Date filed (Month Day Year) 32 Pegietra's Signature	1.0-	7.00		
Registra	r	ALE 2 9 2005 > Tener A	20042			

			1- For State of Ma	ryland / Depa	artment of F	lealth and l		eng 005	30006
I	Physici /Medio	cal	1. Decedent's Name (First, Middle, Last) LAWRENCE 4a. Facility Name (If not institution, give street and number)					Day Year	
	Examir Funeral	ier	RenABANDA Extended CARE 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	× ×	BACTINOR If Under 24 Hrs. Hours Min.	٩	4c. County of Dea	thplace (State or Foreign ountry)
	Director		579-46-8680	70 Yrs.		Thousand the second	May 13,	1935	10d. Inside City Limits
	the Maryi 28a-f sho notified a	rector	Maryland Baltimore			Baltimor		. Citizen of What C	1 TYes 2 No
	th with	al Di	1 West Conway St., #100	8		21202			d States
5-0036	d within 72 hours after death with the Maryland Jiene. I then "natural", or Items 23a or 28a-f show Itte Mauksal Examinat mutt be notified at	d by Funeral Directo	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Amed Forces? 1 Yes, Give Year or Dates:	0	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🗓 No	Specify:	pecify Yes or No- o Rican, etc.)	Specify:	
- - - -	within 72 ene. than "nal	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+	(Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor d)	king 16	6b. Kind of Business	/Industry
7	filed wit Hygiene other the		llth		ironment			Gover	nment
and	be de la	o Be	17. Father's Name (First, Middle, Last) Lawrence E. Taylor, Sr			18. Mother's Nan	ne (First, Middle, Ma Gursta I	-	
Mary	2 should and Men le marks sumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or Ru		City or Town, State,	Zip Code)
altimore, N	is 1 and of Health item 27 other tr		Christine Harrell/Exec. of E 20a. Method of Disposition 1 □ Burial 2 🏋 Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, crer	isition (Name of natory or other plac	ce)	Date 20	c. Location - City or	
altin	parmit. Page Department of Important: If any injury or once.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		rematory Name and Addres			Clintor neral Hon	
ň	E S E S		I olm T. Ilward	111.				h., DC 2	20019
	Physician /Medical		23a. Part1. Ener the disease, or complications that caused to shock or heart failure. List only one cause on each line Immediate cause (Final disease or condition resulting in death)	th death. Do not enter. - Un J C			or respiratory arrest	t,	Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions. b.	consequence of):					
8/00,	sate be executed bhysician and the burial-transit	licai Examiner	that initiated events c.	consequence of):					
. Box 6	ath certific ttending p or use as	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of del Month	ivery Day Year
ecords, P	faw requires that the de- as been signed by the a 2 should be detached f	by P	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderfying cause give	en in Part I.		_	the cause of death?
	Tha ate h	Completed					24a. Was an autopsy performer	d? prior to death?	topsy findings available completion of cause of
VII	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient	0 T F D / 0	t 30 DOA Othe		h (Check only one)		
io uoi	Phy ral o	-	27. Manner of Death 1 Poly Natural 5 Pending (Month, Day) 2 Accident investigation		28c. Injun Work	4 Privatsing Fi	ome 5 ☐ Residence 28d. Describe how	e 6 Other (Specinjury occurred	city)
DIVIS	Ital or Atters after de sal Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injurbuilding, etc.	y - At home, farm, stre (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Aedicai	29a. Certifier (Check only one) 1 Socrtifying Physician: To the best of 2 Medical Examiner: On the basis of e and manner state	examination and/or inv	estigation, in my op	oinion, death occur	red at the time, date	and place, and due	to the cause(s)
^	S T Mile T	M	29b. Signature and title of certifier A. Mounice	M. D	29c. License	2670	24	Date signed (Mont)	
1	13/		30. Name and ddre of rson who completed cause of dead A-MROWIEC 3900 L	21 12.11	Print) en Ba	(L'mo	e MD	21	218
	Sta Registr	_	31. Date filed (Month, Day, Year) AUG 2 6 2005	s Signature	w				

DHMH 17 Rev 1/2001

Tony Tinsley 05**-**05699 RPD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

PD			1 - For State Registrar	State of Maryl		artment o				iene g. No. 0	05	30007
	Physic	ian	Decedent's Name (First, Middle, Last)						2. Date of Deat Month	h Day	Year	3. Time of Death
	/Medi		TONY 4a. Facility Name (If not institution, give s	D.	TINS	1	m, or Location	of Dooth	August			1430 P M
4	Examir	ner			tor		_	or Death		4c. County		oma a la
	Francis		Prince George's H 5. Social Security Number 6. Sec	+	yrs. last birthday)	Chever		r 24 Hrs.	8 Date of Birth			orge's
	Funeral Director				2 Yrs.	Months Da		Min.	8. Date of Birth (Month, Day, FEBRUAR)	Yeal 983	Coul.	place (State or Foreign htry) YLAND
			Usual Residence of Decedent					1	FEDRUAK	1 2		TEMP
	yland		10a. State 10b. County	10c	. City, Town or Lo	ocation						10d. Inside City Limits
	Mar	tor	MD PRINCE G	EORGE'S	BLADEN	SBURG						1X Yes 2 □ No
	r 284	Irec	10e. Street and Number			10f. Zip Coo	de		10	og. Citizen of V	What Cou	ntry?
	daath with tha Maryland ms 23e or 28e-f ehow froust be notified at	O	5034 57th AVENUE	# 101			20710			U.S.A	. •	
	daa	Funeral Director	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent	of Hispanic Or	rigin? (Spec	ofy Yes or No-			can Indian,
9	or its		1 X Never Married 2 ☐ Married	1 ☐ Yes 2 🏹 No If Yes, Give	}	1 ☐ Yes 2 🖾			iican, etc.)		k, White,	etc.
21215-0036	ural',	Completed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		103 200	140 Specily	·-		Specify	BL.	ACK
5	72 h	ete	15. Decedent's Edu (Specify only highest grade	cation completed)	(Give	dent's Usual Oc kind of work do	one durina mo:	st of workin	g	16b. Kind of Bu	usiness/In	dustry
121	hen hen	ם	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use re	ntired)			DDTTA	truz	
	fygia her t		12th 17. Father's Name (First, Middle, Last)		LABO	KEK				PRIVA		
ä	ba fi	Be		R.			MONI ((First, Middle, M HIGDON	faiden Sumam	ne)	
7	nark	မ						•				
Maryland	permit. Pagas 1 and 2 should ba filed within 72 hours after daath with tha Marylan Department of Hauth and Mantat Hygiana. Department of Hauth and Mantat Hygiana. Important: if item 27 is marked other than "natural", or items 23e or 28e-1 show with julury or other traumatic event, the Madical Examinat must be notified at ance.		19a. Informant's Name/Relationship (Ty)						Route Number,			
_	tand Haalt		EARL TINSLEY JR./F		3414 b. Place of Dispo	-			ORESTVI			
٥	gas at of l		1 ☐ Burial 2 ☐ Cremation 3 ☐ R		cemetery, cre	matory or other	place)	Da	ite 2	20c. Location -	City or To	own, State
ţi	t. Pa rtmar rtant njury		4 □Donation 5 □Other (Specify)		RIVERDAI					IVERDAI		
Baltimore,	Dapa Impo eny is		21. Signature of Funeral Service License		2:	2. Name and Ad	dress of Facil	lity J.	B. JENK	INS FUN	ERAL	HOME
	40204		23a. Part1. Enter the diseas or compli	-hall					ANDOVER		AND	20785
	Physician /Medical Examiner	liner	shock, or heart failure ist only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury)			oound e	of head	L			THE PARTY OF THE P	Interval Between Onset and Death
68760,	icata ba axacutad physician and s tha burial-transit	dical Examiner	that indiated events resulting in death) Last	Due to (or as a con	sequence of):							
P.O. Box (that the death certific hed by the ettending p detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	⊒Ectopic pregna ∃ Other (s <i>pecify</i>)				23d. Date Mor	e of delive	ery Day Year
Records, P	w raquiras that tha baan signad by th should ba datache	2	Part II, Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause	given in Part I	l.	23e. Did tob	6.4		ne cause of death?
Ö		lete							24a. Was an	0.45.14		
	ilcian: Tha law cartificata has b ractor, paga 2 s	Completed							autopsy	· D	rior to cor	psy findings available inpletion of cause of
of Vital		Be	25. Was case referred to medical examiner?	ospital:			Othor		Check only one			
of	Phys raldi	5 T	1 ☑ Yes 2 ☐ No '' 27. Manner of Death	X XInpatient	2 ER/Outpatier 28b. Time o	IL SLIDOA	4 🗆 N		e 5 ☐ Resider			
ņ	ding After funar	lo l	1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea.	1.5		njury at Work?		ld. Oescribe how	injury occurre	ed Sut	guet was
Si	Attending r death. ector: After oy the funa	Ca	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	8/22/05			Yes 2		SIU	N		
Division	Dita	Certification;	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	Street				INCL	State) 52LC	60th	Ave. Hyansville
	To the Hospital within 24 hours a for the Funeral complataly filled	edical	29a. Certifier (Check only one) 1 ☐ Cartifying Phys 2 ☐ Medical Examir	sician: To the best of my nar: On the basis of exan and manner stated.	knowledge, deat nination and/or in	h occurred at the vestigation, in m	e time, date ar ny opinion, dea	nd place, an ath occurred	d due to the car f at the time, da	use(s) and mai te and place, a	nner as st and due to	ated. the cause(s)
	To the vithing to the complex	ž	29b. Signature and title of certifier			29c. Lice	ense number		29	d. Date signed	(Month,	Day, Year)
			fanct Doubline	1, MD		0.C	.M.E.		l I	lugust	24, 2	2005
ch	2 (2)		30. Name and address of person who co	mpleted cause of death (
4	0		tamela E. Southa	II, MD	111 Pe		et, Bal	1timon	ce, Mary	land 2	1201	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 6 2005	Registrar's Si	gnature /	W.				THE STATE OF THE S		

DHMH 17 Rev 1/2001

	_	1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of ertificate of			giene 2005	30008
Physic	ian	Decedent's Name (First, Middle, Last) DEPTITE					2. Date of De Month	ath Day Year	3. Time of Death
/Medi	cal	BERTHA ANN BUTLER			4.05.7		AUG 2	29 2005	11:50 P ^M
Exami	ner	4a. Facility Name (If not institution, give s CIVISTA MEDICAL (, or Location of Dea PLATA	ath	4c. County of De	
Funeral	200	5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday	If Under 1 Yea	ar If Under 24 Hi	s. 8. Date of Bir	th o B	thologo /Ctoto or Coroina
Director		217 30 3730	™ XX F 7	O Yrs.	Months Day	rs Hours Min	SEPTEMBE	X 1, 1934 MAR	YLAND
land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
Mary I-feh	ţō	MARYLAND CHARLES	,	NEWBURG					Y Yes 2 No
th the or 288	lrec	10e. Street and Number			10f. Zip Code)		10g. Citizen of What C	ountry?
ath wi	ra l	12961 SHILOH CHURC	H ROAD		206			UNITED ST	ATES
Ite, Middly jidilid ZIZIS-0050 8 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hydene. Item 27 ts marked other then "natural", or items 23a or 28a-f ehow other treumatic event, the Medical Examerar must be notitled at	by Funeral Director	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Evarued Forces? 1 ☐ Yes 2 ▼ Note of Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 N	f Hispanic Origin? (uban, Mexican, Pue lo S <i>pecify:</i>	Specify Yes or No irto Rican, etc.)	0	encan Indian, ite, etc. LACK
72 ho	ted	15. Decedent's Edui (Specify only highest grade	cation	16a. Dece	edent's Usual Occ	supation ne during most of w	artuna	16b. Kind of Busines:	
Men "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	life.	DO NOT use retii	red)	orking		
Hygie thert		5TH GRADE 17. Father's Name (First, Middle, Last)		НО	USEWIFE	19 Mother's N	ama /First Middla	HOME MAK	ER
id be ental	To Be	AUGUSTINE BUTLER					IE LUVENI	,	
cal y call to L L Z Should be filed within and Mental Hygiene. Is marked other then sumatic event, the Market	-	19a. Informant's Name/Relationship (Type			ing Address (Stree			er, City or Town, State,	Zip Code)
and 2 and 2 salth a n 27 ts		CLARENCE J. THOMAS	/ HUSBAN	D 1296	1 SHILOH	CHURCH R	ROAD, NEW	BURG, MARY	LAND 20664
or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ R	emoval from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other p	lace)	Date	20c. Location - City o	Town, State
it. Partimen ritmen ritmant:		4 Donation 5 Other (Specify)		SHILCH CHU				5 NEWBURG,	
permit. Pages 1 and 2 Department of Health a Important: if item 27 ts eny injury or other tre once.		21. Signature of Furteran Service signals LYDIA C. THORNION J	ohnsón moo	583 34	439 LIVI	NGSTON RO	AD, INDI		E, P.A. ARYLAND 20640
		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	eations that caused to e cause on each line	e. / .		ying, such as cardia	ac or respiratory ar	rest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	Con restin	e Heart	tailure				Onset and Death
/Medical Examiner		Tooding in county	ue to (or as a	consequence of):					
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		consequence of):					
cuted nd ransit	Examiner	that initiated events							
be executed sicien and burial-transit		resulting in death) Last	Due to (or as a	consequence of):					
1	edical	d							
auth certific attending p for use as	√Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of	f pregnancy				23d Date of de	line
The law requires that the death cert are hes been signed by the attending agge 2 should be detached for use	Physician/M	in the past 12 months?	1□Live birth 2 4□Pregnant at ti	Fetal death 3	□Ectopic pregnan □ Other (specify)			23d. Date of de Month	Day Year
that the de	hys	9 Unknown	9□ Unknown						
es tha igned be de	by	Part II. Other significant conditions con	tributing to death but	not resulting in the u	inderlying cause g	given in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
w require been si	ed						1 🗆 Y	′es 2 ☐ Mr⁄o 3 ☐ P	robably 4 □Unknown
e law hes b	Completed						24a. Was autop	sv prior to	utopsy findings available completion of cause of
	e Co	25. Was case referred to medical					1 ☐ Yes	2 No 1 ☐ Yes	2 13 No
ysicien: is certification, director, p	0 0	examiner?	ospital:	t 2 ER/Outpatie	nt 3 DOA O	M	eath Check only o	ne lence 6 □Other (Spe	
Attending Physicien: or death. ector: After this certific by the funeral director,	ı,	27. Manrer of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	28b. Time o			7	now injury occurred	city)
eath. or: Af	catic	2 Accident investigation	(1111111)	, out,		Yes 2 □No			
ء ۾ ڇُ ج	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, st (Specify)	reet, factory, office	В	28f. Location (S City or Tow	Street and Number or Ri m, State)	ural Route Number,
Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying Phys	ician: To the best of	my knowledge deat	h occurred at the	time, date and plac	e and due to the	cause(s) and manner as	- state-d
the Ho hin 24 h the Fur	Medical	(Check only 2 Medical Examination)	er: On the basis of e and manner state	examination and/or in	vestigation, in my	opinion, death occ	urred at the time, o	date and place, and due	o to the cause(s)
To the within To the comp	Ž	29b. Signature and title of certifier	0		29c. Licer	nse number		29d. Date signed (Mont	h, Day, Year)
\		Mytha	W			-0058095		08/30/20	05
RA		30. Name and address of person who con						,	
Sta	rte.	TONYA L. HARDY MD 31. Date filed (Month, Day, Year)	11345 PEMI 32. Resistrar	BROOKE SQ	-STE 104	4 WALDORF	, MD 2060	93	
Regist		31. Date filed (Month, Day, Year) AUG 3 1 20	05 Steel	BROOKE SQ	Cart o				

	an al	Kristian s.		SSen			Nouth	30 2	1302P
Examin	er	4a. Facility Name (If not institution, g		r)	4b. City, Town,	or Location of Death		4c. County	
		LONGVIEW NURSI 5. Social Security Number 6.		Age (In yrs. last birtho		MANCHESTER r If Under 24 Hrs.	8. Date of Birth		ROLL
Funeral Director		082-10-9877 Usual Residence of Decedent	1 X M 2□ F	87 Yrs	Months Days		(Month, Day,	Year)	9. Birthplace (State or Fore Country) NORWAY
show		10a. State 10b. County		10c. City, Town o	or Location				10d. Inside City Lim
ath with the Maryland 123a or 28a-f show ust be notified at	Director	DELAWARE NEW	CASTLE			NEWARK			1 □ Yes 2 X]
Vih t	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Country?
s 23	erai	23 LONGVIEW DR	IVE 12. Was Deceder	u Sugria II S		19711			STATES OF AME
be filed within 72 hours after dea ital Hygiene. Id other than "natural", or flems svent, I'le Medical Exter-ine file	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces	s?		Hispanic Origin? (Sp ban, Mexican, Puerto	Rican, etc.)	Blad	ce - American Indian, ck, White, etc.
rai', o	þ	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	::	1 ☐ Yes 2 🛣 No	Specify:		Specify	y: WHITE
"natural",	Completed	15. Decedent's (Specify only highest g	Education rade completed)	1 (6	ecedent's Usual Occu	e during most of work	tina	16b. Kind of B	usiness/Industry
within ane. then	mp	Elementary/Secondary (0-12)	College (1-4o	r 5+)	fe. DO NOT use retir	ed)			
e filed within al Hygiene. I other then '		17. Father's Name (First, Middle, Las	st)	5	TOREKEEPEI	18. Mother's Nam	e (First Middle M	OIL RE	
id be ental ked o	To Be	THORALF E. THOM				GUNDA	FOLFWO		
2 should be and Mental is marked c	-	19a. Informant's Name/Relationship		19b. M	lailing Address (Stree	et and Number or Rur			State, Zip Code)
s 1 and 2 should f Health and Men fem 27 is marke other treumatic		ELIZABETH ANN T	HOMASSEN/I						CHESTER, MD 2
		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3		20b. Place of Di	isposition (Name of		Date	20c. Location -	City or Town, State
Page ment o ant: if ury or		`4 □ Donation 5 □ Other (Spec		MEMORIAI	L CEMETERY	SEPT.	7,2005	BEA	R. DE
permit. Page Depertment of Important: If any injury or once.		21. Signature of Funeral Service Lic	ensee MOC	0840	22. Name and Addr	ess of Facility LLIKIN FUN	EDAT HON	AEC TN	r.
20599	_	23a. Part1. Enter the disease, or co	1		1000 N. DU	JPONT PKWY	., NEW C	ASTLE,	DE 19720
Medical Lysician and The burial-transit	Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or a	is a consequence of): as a consequence of): as a consequence of):				8	411
the death certificate be y the attending physicia iched for use as the bu	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death at time of death	3 □Ectopic pregnant 5 □ Other (specify) _	су		23d. Dai	te of delivery nnth Day Year
gne be c	۵	Part II. Other significant conditions	contributing to death	but not resulting in th	e underlying cause g	iven in Part I.			ribute to the cause of death?
The law ate has b page 2 st	Completed						24a. Was ar autops perform 1 \(\text{Yes} \) 2	red?	Were autopsy findings availated from the completion of cause of death?
Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0	26. Place of Deat	n (Check only one	9)	
Phys	ဥ	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 🗀 Inpa		Illent 3L DOA		me 5 Reside		
To the Hospitel or Attending Physician: To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	bo .	njury - At home, farm, etc. (Specify)	ry Wo	Yes 2 □ No		reet and Numb	er or Rural Route Number,
s Hospitei 124 hours a e Funerel l letely filled	Medical Co	29a. Certifier (Check only one) 1 Certifying F	Physician: To the bes aminer: On the basis and manner:	st of my knowledge, do of examination and/o stated.	eath occurred at the t r investigation, in my	ime, date and place, opinion, death occurr	and due to the ca ed at the time, da	use(s) and ma ite and place, a	inner as stated. and due to the cause(s)
To the within 2 To the complet	Me	29b. Signature and tale of certifier			29c. Licen	se number	29	d. Date signed	d (Month, Day, Year)
		1111			-	33165		0/	RE OT

			1 - For Stete Registrar	State of M	aryland / Depa <i>Ce</i>	artment of H	lealth and Death	Mental Hy	giene Reg. No.20	05	30010
	Physic	ian	Decedent's Name (First, Middle, L.	ast)				2. Date of D		Year	3. Time of Death
	/Medi	cal.	Willimena Dori					Augus	t 23 2	2005	1:05 A M
	Exami	ner	4a. Facility Name (If not institution, gr 2301 Valley			4b. City, Town, o	r Location of Dea Waldorf	ath	4c. County		s County
H	Funeral		5. Social Security Number 6.	Sex _ 7. Ag	ne (In yrs. last birthday)	If Under 1 Year	If Under 24 Hr	s. 8. Date of Bi	irth	9. Birtho	lace (State or Foreign
н	Director		0/9-24-2154	1□M 2X1F	7.5 Yrs.	Months Days	Hours Mir	June 1	tth ay, Year) 4, 1930	South	Carolina
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				1	Od. Inside City Limits
	Mary a-f sh	tor	Maryland Cha	rles			Waldo	rf			1 ☐Yes 2 ☐ No
	ith the	Oirec	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Coun	try?
	s 23a	Funeral Director		ley Oak Co			20601				States
	iter de Items	une	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 Yes 2 X	Ever in U.S. 13.1	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (an, Mexican, Pue	Specify Yes or No irto Rican, etc.)	o- 14. Rad Blad	e - Americ ck, White,	an Indian, Pican
036	al', or	by	3 ☐ Widowed 4 🔀 Divorced	If Yes, Give Year or Dates:		1□Yes 2XNo	Specify:		Specify		nerican
21215-0036	72 hc	Completed by	15. Decedent's 8 (Specify only highest gi	Education rade completed)	(Give	dent's Usual Occup	during most of w	orkin a	16b. Kind of Bu	usiness/Ind	lustry
121	within ane. then '	mp	Elementary/Secondary (0-12)	College (1-4or	life	DO NOT use retired	4)	•	D		
d 2	Hiled Hygid other ent, II	Be Co	12th 17. Father's Name (First, Middle, Las	t)		Assen		ame (First, Middle		ivate	2
/lan	wid be Mental arked	To B	William	Smiley, Sr	•				ie Fludd	-	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturar", or items 23a or 28a-f show any injury or other treumatic event. The Medical Exemples in with be multilled at once.		19a. Informant's Name/Relationship Joyce Terry -			g Address (Street 01 Valley				State, Zip 20601	
	s 1 and f Heal item 2 other		20a. Method of Disposition		20b. Place of Dispo	sition (Name of		Date	20c. Location -		
Baltimore,	Page nent o int: If iry or		1 ☐ Burial 2 ☐ Cremation 3 [Lincoln	natory`or other plac Memorial		29/2005	Suit1	and.	MD
Salt	permit. Departri Importa any inju		21. Signature of Funeral Service Lice	nsee	The state of the s	. Name and Addres	ss of Facility	Stewart	Funeral	Home	2
	205 29		John .	Melibar			_	d., N.E.		DC 20	0019
	Dharistan		23a. Part1. En er the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each in	10.				rrest,	ŀ	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	nic Obstru	ctive Pul	Lmonary	Disease			
	Examiner		Sequentially list conditions.	b							
	ed sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence or,						
Ć,	execut n and al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of):					-	
68760,	cate be executed physician and the burial-transit	dicail		d							
		0	IF FEMALE:								
Вох	death certific e attending p id for use as	clan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of deliver	y Day Year
0.		Physician/M	1 ☐ Yes 2 🔼 No 9 ☐ Unknown	9□ Unknown	une or death 3	Other (specify)					
s, P	Se us	by P	Part II. Other significant conditions	contributing to death be	ut not resulting in the ur	derlying cause give	en in Part I.	23e. Did t	obacco use contr	ibute to the	cause of death?
ord	w requir been si should	eted	Diabetes					1 🛣	Yes 2□No	3 Proba	bly 4 ∐Unknown
Record	has b	Completed	Congestive He	art Failur	e			24a. Was autop	osy p	Vere autoportion to come eath?	sy findings available pletion of cause of
Vital		e Co	Cor Pulmonale				00.00	1 ☐ Yes	2 X No 1	Yes 2	2 □ No
f Vi	S S	To B	examiner?	Hospital: 1 Inpatie	nt 2 ☐ ER/Outpatient	3□ DOA Othe		ath <i>(Check only o</i> Home 5 XResid		ar (Snecify)	3000 TO 1
n of			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time of Injury	28c. Injury Work	at		now injury occurre		
Division	Attending ir death. ector: After by the fune	icatl	2 Accident investigation 3 Suicide 6 Could not be	OB Blace of Init	and Athema farm star		/es 2 □ No	00()			
Div	7 4 7 6	Certification:	4 Homicide determined	building, etc	iry - At home, farm, stre c. (Specify)	et, factory, office		City or Tox	Street and Numbe vn, State)	or or Rural	Route Number,
	To the Hospitel c within 24 hours at To the Funerel D completely filled in	edical (29a. Certifier 1 Certifying Pl (Check only one) 2 Medicel Exel	nysicien: To the best of miner: On the basis of and manner sta	of my knowledge, death examination and/or inv ted.	occurred at the timestigation, in my op	e, date and place inion, death occu	e, and due to the ourred at the time,	cause(s) and mar date and place, a	nner as star nd due to t	ted. he cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed	(Month, D	ay, Year)
	5.		Colul MAR	yus -			21240		Aug	ust 2	.6, 2005
	BJ		30. Name and address of person who		eath (Item 23a) (Type, F		+ N D	Uc −1-	DG 2000	2	
	Sta	te	31. Date filed (Month, Day, Year)	oso, M.D. 32. Registra	1011 N. (Sapitol S	N.E.	. wasn.,	DC 2000		
	Registr	ar:	AUG 3 0 2005	32. Hegistra	grace						

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	Physici	an	1. Decedent's Name (F	irst, Middle, L				¥7				2. Date of Dea	ath Day	V-U-5	3. Firme of Coatt
	/Medio		4a. Facility Name (If no	t institution, ai	Dinh	er)		Vo 4h City	Town or	Location of	of Death	August		005 nty of Death	8:57 A M
	Exami	ler	Shady Grov						cvill		or Dodui			tgomer	37
	Funeral		5. Social Security Numb	ber 6.	Sex 7.		last birthday)	If Under	r 1 Year	If Under		8. Date of Birt	h	9. Birthp	place (State or Foreign
	Director		213 31 907	0	1 ⊈ M 2□F	32	Yrs.	Months	Days	Hours	Min.	Month, Day		Viet	Nam
pue	3		Usual Residence of De 10a. State 10	cedent b. County		10c Cit	y, Town or Lo	cation							
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the the	288	Director	10e. Street and Numbe	Montgo	шегу	211	lver Sj	10f. Zig	Code				10g. Citizen o	of What Cour	
ž.	3a o.		410 East F	rankli	n Avenue				209	001			. og. Ozom	USA	10 9 1
1215-0036 within 72 hours after death with the Maryland	E I	Funeral	11. Marital Status		12. Was Deceder Armed Force	nt Ever in U.	.S. 13.	Was Dece			gin? (Spe	cify Yes or No- Rican, etc.)	14. R	ace - Americ	
Se je	유립	臣	1 Never Married		1 Yes 2			1		Specify:	i, Puerto F	rican, etc.)		lack, White,	
21215-0036 of within 72 hours at	and and	d by	3 Widowed 4		Year or Dates	s:			2,00110	opecity.			Spec	ity: Asi	an
1 5	in the	Completed		. Decedent's E only highest gi	ducation ade completed)		16a. Dece (Give	dent's Usua kind of wo DO NOT u	rk done d	urina most	t of workin	ng	16b. Kind of	Business/Ind	dustry
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2 2	Hyg offi-		17. Father's Name (Firs	it, Middle, Las	<u>-</u>		СОщре	icer 1			r's Name	(First, Middle,	Comput		mpany
Maryland	ked ked ic ev	To Be	Cam Dinh	Vo						Hanh	Th				
ary spo	ema uma		19a. Informant's Name	/Relationship	(Type, Print)		19b. Maili	ng Address	(Street a	nd Numbe	r or Rural	Route Numbe	r, City or Tow	n, State, Zip	Code)
Z , d	elth a		Tuanh Dinh	/ Wife	2		25505					e Silve			
ore s	of He		20a. Method of Disposit		70	1 0	lace of Dispo	sition (Nar	ne of		Da	ate	20c. Location	1 - City or To	wn, State
Ë å	Le ur :		4 Donation 5		Removal from State						7 9/1	/2005	Silver	Spri	ng,Maryland
Baltimore,	Department of Heelth and Mental Hygiane. Important: or Items 23a or 28a-f ehow any injury of other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funera	al Service Lice	nsaé (22	. Name an	d Addres	s of Facility	Hine	s Rinal	ldi Fur	neral 1	Home
		-	23at Part1. Enter the d	CK	Mein	bu								pring	, MD 20904
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ecords, P.O. Box 68760, law requires that the death certificate be executed	by the attending phatached for use es th	hysiclan/Me	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nths?	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Fetal at time of de	déath 3⊡ eath 5⊡	Ectopic pr	ecify)					late of deliver	ry Day Year
rds, F quires tha	been signed t should be deta	۵	Part II. Other significan	t conditions	contributing to death	but not resu	ulting in the ur	nderlying ca	ause giver	n in Part I.		23e. Did tol	V		ably 4 Unknown
E \$	page	Completed										24a. Was a autops perform	y	prior to con death?	sy findings available apletion of cause of
	this certifica al director, I	20	25. Was case referred t examiner? 1 Yes 2 No	o medical	Hospital:			- 11 - 10 F				(Check only on	1		
o Ę	ar this aral d	2	27. Manner of Death		1 ☐ Inpat	jury	ER/Outpation 28b. Time of		A	4 U Nur		e 5 ☐ Reside			vator of
0 g	th. : After s funer	tlor	1 □Natural 5 2 X Accident	☐ Pending investigatio	(Month, D	ay Year)	Injury	A-M	8c. Injury : Work?	s 2 (27N)	lo I	Motora 41	cle iv		A
DIVISION OF	s efter death.	Certification		Could not b	e 28e. Place of Ir	njury - At ho	me, farm, stre			-7		3f. Location (St	reet and Num		Route Number
ב ב	a Dir	Cert	4 Homelde		building, e	etc. (Specify,		war	1			City or Town	10	21465	kylav K.Rd
the Hospital or	within 24 hours efter To the Funaral Dis completely filled in	Medical	29a. Certifier 1 (Check only one)	Certifying Ph Medical Exar	ysician: To the bes niner: On the basis and manner s	or examinati	vledge, death ion and/or inv	occurred estigation,	at the time in my opi	, date and nion, death	place, an	d due to the ca	uso(s) and m	conner ac cte	atod.
To	Nith S	Σ	29b. Signature and title	of certifier	1			29c	License	number		2	9d. Date signe	ed (Month, E	Pey, Year)
7	3(8)		Care	de1	tallai	1 W	d	0	.C.M	.E.		A	ugust	27, 20	005
			30. Name and address of	of person who	completed cause of	death (Item	23a) (Type, I	Print)							
			CAROL	- 14 1	MILLIA	MO	2	11:	l Per	n Stı	reet,	Baltir	nore. N	Maryla	nd 21201
	Star Registra		31. Date filed (Month, D		32. He sis	trar's Signati	ure	artes						ACTOR DESCRIPTION	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 1tem 29d per doc 8048 IU-I7-D5 Vt.
State of Maryland / Department of Health and Mental Hygiene 0 5 30012 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 28, 2005 William August 1:50 A Glenn Wood, Jr. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Charles 11440 Wicomico Oaks Place Charlotte Hall | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug . 17, 192 7. Age (In yrs. last birthday) 76 Yrs. 5. Social Security Number 6 Sex Birthplace (State or Foreign
Country) Months 1**™** M 2□ F 116-24-6489 1929 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Charles Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Oaks Place 20622 11440 Wicomico U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

12) Yes 2 □ No

17 as Give Year of 959 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: SpecifyWhite 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Airline Captain Airline 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Glenn William Wood, Sr. Lillian Crouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 20622 19a. Informant's Name/Relationship (Type, Print) 11440 Wicomico Oaks Place, Charlotte Hall, MD Mary Reeves Wood/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Raeford Cemetery 9-1-05 Raeford, NC 21. Signature of Funeral Service Licenses Arehart-Echols Funeral P.O. Box 567 La Pata, M00817 MD 20646.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) JUKNOW Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 D No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 | Yes 2 | 3 DOA

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

MD

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Funeral

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Completed

Be

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" ~ ... any injury or other traumatic aver.

attending physician and for use as the burial-transit Physician/Medical þ Completed Be 2 Certification:

has

certificate

this

within 24 hours a

Medical

State

Registrar

The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

Vital

Division of

To the Hospital or Attanding Physician:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

27. Manner of Death

Natural 2 Accident

3 Suicide

29a, Certifier

4 ☐ Homicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

5 | Pending investigation

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

31. Date filed (Month, Day, Year)

12

AUG 3 1 2005

egistrar's Signature 32

DHMH 17 Rev 1/2001

		Registrar						ertifica	te of l	Death			Reg. No	2.0	0 =	200-11
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aminer	48	a. Facility Name (/			reet and nu	mber)			, Town, or		of Death				of Death	
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eral ctor		Social Security N 156-05-9 sual Residence of	140	6. Sex	M 2□ F		n yrs. last birtho 84	Months	er 1 Year Days	Hours	Min.	8. Date of B (Month, D 09 2	irth 20 20		Cour	lace (State or Foreig ntry) rginia
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DHMH 17 Rev 1/2001

		1	For State Registrar	State of Ma	•	partment of Hertificate of I			iene 2005	30015
			Decedent's Name (First, Middle	, Last)				2. Date of Deat Month	h Day Year	3. Time of Death
	Physicia /Medic		DAVID	WOOD	JR			AUGUST 2	•	12:28 P M
	Examin		a. Facility Name (If not institution	give street and number)		4b. City, Town, or	r Location of Death		4c. County of Dea	
				YLAND HOSPITA		CLINTO		8. Date of Birth	PRINCE O	
	Funeral		5. Social Security Number	6. Sex 7. Age 1 ☐ M 2 ☐ F	(In yrs. last birthda CO Yrs.	Months Davs	Hours Min.	(Month, Day,	Year 1936 S. C.	thplace (State or Foreign ountry)
	Director	-	225-44-9882 Usual Residence of Decedent	Δ.	68 Yrs.			SEPTEME	BER 20 Vir	dinia
	/land		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mar.	ţċ	MD PRINC	E GEORGE'S	LANHA	AM				1X Yes 2 □ No
	or 28	Olre	10e. Street and Number			10f. Zip Code	_	1	0g. Citizen of What C	ountry?
	23e	la l	7811 DELLWOOD			2070			U.S.A.	
	tems	Funeral Director	11. Marital Status	12. Was Decedent E- Armed Forces?		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S) an, Mexican, Puert	o Rican, etc.)	14. Race - Am Black, Whi	
36	rs aft		1 ☐ Never Married 2 🔯 Marr 3 ☐ Widowed 4 ☐ Divorced	ed 1 TYes 2 No If Yes, Give Year or Dates:	NAVY	1 ☐ Yes 2 🛱 No	Specify:		Specify:	BLACK
21215-0036	ilied within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23e or 28e-f show out, It e Marical Examinar must be molified at	Completed by	15. Deceden	's Education	16a. De	cedent's Usual Occup	ation	king	16b. Kind of Business	
215	hin 7.	ple	(Specify only highes Elementary/Secondary (0-12)	College (1-4or 5+) life	e. DO NOT use retired	d) -	wing		
	ad wit	Con	12th		DI	ETARY SUPE		45 . AC 4 ft	GOVERNME	NT
lud	be fill ad oth even	Be	17. Father's Name (First, Middle, DAVID WOOD	SR.					Maiden Sumame) IPBELL	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28a-1 show important: If item 27 is marked other then "natural", or items 23e or 28a-1 show any injury or other treatmetic event, if a Marical Examinal must be notified at once.	ဥ	19a. Informant's Name/Relations	nin (Tuna Print)	19h M	ailing Address /Street	SALLY		City or Town, State,	Zin Code)
Ma	d 2 st th and 7 Is r treur	r Y	LUCY WOOD/WI			1 DELLWOOI				20706
	1 and Health Iem 27 other tr		20a. Method of Disposition		20b. Place of Di	sposition (Name of crematory or other place	cal	Date	20c. Location - City o	r Town, State
JO L	Pages nent of H ant: If ite ary or of		1 □XBurial 2 □ Cremation 4 □ Donation 5 □ Other (S			and Vetera		05	Cheltenham	n,Maryland
Baltimore,	permit. F Departme Importer eny injur	1	21. Signature of Funeral Service			22. Name and Addre	ss of Facility J		KINS FUNER	
ä	Depa Impo eny ir	6. 0	X. D. Ma	heell					ER, MARYLA	ND 20785
	THE ST	d)	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each line	the death. Do not	enter the mode of dyir	ng, such as cardiad	or respiratory arr	est,	Approximate Interval Between
	Physician	8 II	Immediate Cause (Final disease or condition	Myc	scardi	al Info	avction			Onset and Death
	/Medical Examiner		resulting in death)		consequence of):	Λ \	Drease			
b	Examine		Sequentially list conditions,	b	consequence of):	treey	Margue			
	led nsit	nine	il any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Deorio (or de s	eonesquarios or,					
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8760,	cate be executed oblysician and the burial-transit			d						
9	tificat ng phy as th	fedi						-		
Box	death certific e attending p id for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth		3 □Ectopic pregnanc	y		23d. Date of de Month	elivery Day Year
	that the death certific ed by the attending p detached for use as	by Physiclan/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	ime of death	5 Other (specify)			No.	buy
P.0	nat the d by th fetache	Phy	Part II. Other significant conditi	ons contributing to death bu	t not resulting in th	e underlying cause on	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ds,	w requires that s been signed b should be deta		Tarri, Other signment series					1 🗆 Y	es 2□No 3□F	robably 4 🖫 Unknown
Sor	> 0 7	ete						24a. Wasa	n 24b. Were a	autopsy findings available
Re	e la has je 2	Completed						autop: perfor	sy prior to med? death? 2 ■ No 1 □ Ye	
of Vital Record	icien: Th certificate rector, pag	a	25. Was case referred to medica	1			26. Place of Dea	ath (Check only or		223110
ΓV		To B	examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 Inpatie	nt 2 ER/Outpa	atient 3 DOA	her: 4 🗌 Nursing F	lome 5 Resid	ence 6 Other (Sp	ecity)
			27. Manner of Death 1 Natural 5 □ Pendii	28a. Date of Injur (Month, Day	y 28b. Tim Year) Inju	ry Wo		28d. Describe h	ow injury occurred	
sion	tendir leath. Icr: Al	atic	2 Accident investi	gation			Yes 2 □ No	005 1	Access and Marines and	Zum I Davida Alumbian
Division	l or Attanding after death. Director: After In by the tune	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		ry - At home, farm . <i>(Specify)</i>	, street, factory, office		City or Tow	treet and Number or F n, State)	Rurai Houte Number,
	Hospitel 1944 hours a Funerel C		29a, Certifier	ng Physician: To the best of	f my knowledge o	leath occurred at the ti	ime, date and place	and due to the o	ause(s) and manner	as stated.
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical	(Check only 2 Medical one)	Examiner: On the basis of and manner sta	examination and/o	r investigation, in my	opinion, death occu	irred at the time, o	late and place, and du	e to the cause(s)
	To the within 2 To the complet	₩	29b. Signature and title of certifie	or		29c. Licen	se number		29d. Date signed (Mor	nth, Day, Year)
	- > - 0		*			Do	06141	5 P	ruguet :	26, 2005
0	(IE)		30. Name and address of rerson	who completed cause of de	eath (Item 23a) (Ty	rpe, Print)	1.57			
2	(2)		1 3	ubhir, M.D	-500ther	n Alconyland H	uspital 750.	Sunatts	Rund Chiston	26, 2005 1, MD. 20735
		ate	31. Date filed (Month, Day, Year AUG 3 0 20	32. Registra	r's Signature	while I				
	Regist	rar	7040 120	The same	~ /7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 8 per fh g84/ 9-26-05 vt

		·	1- State Registra VEND#8perFH9/6	State of Maryllar 5/05,BMV,McCo		tment of H			giene Reg. No. 2	05	30016
E	Dhysisi		1. Decedent's Name (First, Middle, Las	,				2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medic		11- 8-1	DICIECT				03	27	02	1024 AM
	Examin	er	4a. Facility Name (If not institution, give Mow Tadmerky	GENERAL H	DIPITAL	4b. City, Town, o	SEY, M	10		ty of Death	MERY
	Funeral Director		5. Social Security Number 6. Se 186 - 07 - 2297	7. Age (In yrs.	last birthday) Yrs.	Months Days	Hours M	in. (Month, Da	y, Year)	Cour	place (State or Foreign ntry) sylvania
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity. Town or Loca	ation		7-28-19	18	1	IOd. Inside City Limits
	f sho	ō	Maryland Montgom		Sandy S						1 ☐ Yes 2 X No
	r 28e-	rect	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
	th with	ai D	1639 Hickory K	noll Road		208	60		Unite	d Sta	ites
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importents If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other treumatic avant, the Medical Evartical must be rediffed at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	as Decedent of H Yes, specify Cubin		(Specify Yes or No erto Rican, etc.)	Speci	ack, White, ify: Wh	
21215-0036	nin 72 ho in "natur Wedical I	Completed by	15. Decedent's Ed (Specify only highest gra-		(Give k	nt's Usual Occup ind of work done O NOT use retire	during most of	working	16b, Kind of I	3usiness/In	dustry
212	ar tha	Com	10	College (1-401 5+)	Homen	naker			Own Ho	me	
pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle,	Maiden Suma	me)	
ryla	d Men narke	L C	Albert Ciesielka		405 14-11-	Add (C)		y Stossel	- 0" - T	0 7	. 0. 11
Maryland	d 2 st th and t7 ia n treun		19a. Informant's Name/Relationship (7 Sr. Victoria Raj	• • • • • • • • • • • • • • • • • • • •				N.E. Was			•
ē,	The all		20a. Method of Disposition	20b.	Place of Disposi	tion (Name of		Date	20c. Location		
OE .	Pages ient of nt: Fi		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Hemoval from State	*	atory or other place. Cemete:	ry Sej	pt. 2,	Yeadon	. Pen	nsylvania
Baltimore,	permit. Departrr Importe any inju		21. Signature of Funeral Service Licenter	300				DeVol Fundanth	eral Ho	me	20877
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	Examiner		ſ	CEREBRO	quence of):	MAR	ACCID	ENT		1	1 DAYC
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9	tificate ig phy as the	ledic		d							
Вох	death certific e attending p cd for use as	Physician/Me	in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 6	al death 3 □E	ctopic pregnancy	y			ate of delive	ery Day Year
o.	0 0 0	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknown		- (openin)					
ds, P	es pe pe	by	Part II. Other significant conditions co	ontributing to death but not re-	sulting in the unc	derlying cause giv	ven in Part I.	23e. Did to	_		ne cause of death?
Record	> 0 0	ompieted						24a. Was			psy findings available
R	9 7 9	mo							rmed? 2 🔯 No	prior to cor death? 1 Yes	mpletion of cause of
Vital	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					Death (Check only o			
of <	Physician: this certific ral director,	၉	1 ☐ Yes 2 ☑ No		ER/Outpatient		4 Nursing	g Home 5 Resid		-	y)
uc	ding After fune	ion	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1 🗆	yat k? Yes 2.⊟No	28d. Describe h	low injury occu	rred	
Division	To the Hospitel or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	ertification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		nome, farm, stree		163 2 110	28f. Location (S City or Tox		ber or Rura	l Route Number,
	urs aft	0		<u> </u>				<u>H</u>			
	e Hospitel 24 hours a a Funaral I	edicai	29a. Certifier Certifying Phy (Check only one) 2 Medical Example	ysician: To the best of my kniner: On the basis of examinating and manner stated.	owledge, death o ation and/or inve	occurred at the tirestigation, in my c	me, date and pla ppinion, death o	ace, and due to the o courred at the time,	cause(s) and m date and place,	anner as st and due to	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signe	ed (Month,	Day, Year)
	1		PACU	4		Pate	129710	7	8/29/0	,5	
	φ		30. Name and address of person who o	completed cause of death (Ite	m 23a) (Type, P	rint)	50	- 171	N 0 -	22.	
	- Ct	10	SONIA HELMES, M. 31. Date filed (Month, Day, Year)	32. registrar's Sign	ature -	THILLY !	DRIVE	orner h	113 1208	152	
	Sta Registr			005 Brews	b. Apa	well					

			For State	State	of Mary	land / Dep <i>Ce</i>	artment of I rtificate of	lealth and	Mental Hy		05	30017
			1. Decedent's Name (First, Middle	le, Last)			runoato or	Dealit	2. Date of Dea	Reg. No.		3. Time of Death
П	Physica /Medi		ROZELL	DORSEY	7 WT1	LSON			August	Day 23,2	Year	8:15A M
	Examir		4a. Facility Name (If not institution			<u> </u>	4b. City, Town, o	or Location of Dea		4c. County		10.13A
			Montgomery (General	Hosp:	ital	Olne	V		Mont	aome	rv
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🛣 F	7. Age (In	yrs. last birthday,		If Under 24 Hr		Year)	9. Birtho	place (State or Foreign
	Director		216-40-5456 Usual Residence of Decedent		0.	3 Yrs.			Junez	1,1942	Ma	ryland
	land ow		10a. State 10b. County		10c	. City, Town or L	ocation				1	0d. Inside City Limits
	Many 1 sh	to	MD Mor	ntgomery	7	Olne	V					1 X Yes 2 □ No
	th the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of \	What Cour	ntry?
	23a c	aiD	17500 Georgi	ia Ave			2	0832		U - 9	3.A.	
	filed within 72 hours after death with the Maryland Hygiene. uther than "neturel", or Items 23a or 28e-1 show ont, the Medical Examinat Les routilled at	Funerai	11. Marital Status	Armed F		in U.S. 13.	Was Decedent of H	Hispanic Origin? (an, Mexican, Pue	Specify Yes or No-	14. Rac	e - Americ	
36	s afte	by Fi	1 Never Married 2 Mar 3 Widowed 4 Divorced	If Vac G	24∑No ive		1 □ Yes 2 ♣No	Specify:		Specify		lack
5-0036	2 hou			nt's Education	Dates.	16a, Dece	dent's Usual Occup	pation		16b. Kind of Bi		
212	nin 7%	Completed		st grade completed	(1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wo d)	orking			,
2121	d with giene er tha	mo:	Lioinentary/Secondary (0°12)	2yr		Bu	s Drive	r		City	of :	Rockville
ਠ		0	17. Father's Name (First, Middle,	Last)				18. Mother's Na	ame (First, Middle,	Maiden Suman	ie)	
yla	Mental I	L _O	William C		У				ngeline			
Maryland	12 sh and Is m		19a. Informant's Name/Relations						Rural Route Numbe			
e)	1 and Health Bm 27 ther t		William Bray 20a. Method of Disposition	ton- so		4 Z 5 L	Star C	ircle F	Randalls Date			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menia. Importent: If item 27 Is marked eny injury or other treumatic ov one.		1 Burial 2 Cremation		n State	•	osition (Name of matory or other pla	1		20c. Location -		ring,MD
	artme ortent injury		4 Donation 5 Other (S 21. Signature of Funeral Service) //	G		Heaven 2. Name and Addre		_/3005 _			
m m	Dep imb		Howar K	8110	les &	20 0000			nowden	Funera	T HO	ome, P.A. MD 20850
	1 5 6		23a. Part1. Enter the disease, or shock, or hear failure. List	complications that	caused the						.1e,r	Approximate
	Physician		Immediate Cause (Final				REAST C					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a.		sequence of):	KEASI C	ANCER			-	
	Examiner		Sequentially list conditions,	h							4	
	D H	iner	il any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dus to	(or as a con	is aquaited of j.						
	and and I-trans	Examine	that initiated events resulting in death) Last	c. Due to	Or as a con	sequence of);						
8/60,	death certificate be executed e attending physician and nd for use as the burial-transit	aE			(0. 40 4 0011	34431103 317.						
289	ficate physics the	edical		d.								
ROX	leath certific attending pl	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or						23d. Dat	e of delive	rv
	death	icia	in the past 12 months?		birth 2 □ F nant at time		Ectopic pregnancy Other (specify)	<i>'</i>		Mor		Day Year
J.	at the de by the a	hys	9 🗆 Unknown									
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant condition	ns contributing to	death but not	resulting in the u	nderlying cause giv	en in Part I.				e cause of death?
0	w require been sig should b	ted							1 L Ye	s 2LfNo	3 Proba	ably 4 □Unknown
Records,	e taw has b	Completed							24a. Was a autops	V D	Vere autor	osy findings available apletion of cause of
	Th ate pag								perform	No 1	eath?	2 X No
VItal	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	44 44 4			. all post Oth		ath Check onl on			
O	Phys ar this aral di	\vdash	27. Manner of Death		Inpatient 2 of Injury oth, Day Year	2 ER/Outpatier 28b. Time of	3 DOA	4 Nursing F	Home 5 Reside)
0	Attending I r death. ector: After by the funer	atio	Natural 5 ☐ Pendin 2 ☐ Accident investi		nth, Day Yea	r) Injury		k? Yes 2 □No		. ,		
DIVISION	r Atte er deg recto by th	ertification;	3 Suicide 6 Could	ined 200. Plac	e of Injury · A	At home, farm, str	eet, factory, office		28f. Location (St City or Town	reet and Number	or Rural	Route Number,
5	itel on rs aft rel Di	Cer		M						,		
	To the Hospitel or Attendin within 24 hours after death. To the Funerel Director: Att completely filled in by the fun	icai	Chock only 2 Infourcat	ng Physician: To th Examiner: On the I	dasis of exam	knowledge, death nination and/or in	occurred at the time vestigation, in my o	ne, date and place	e, and due to the caurred at the time, do	use(s) and mar	ner as sta	ated. the cause(s)
	thin 2 the mplet	Medical	29b. Signature and title of certifie	anu mar	nner stated.		29c. License			9d. Date signed		
	7. ¥ 7. 8) (de	- ~ \	. ^	n		35635	2	-		, 2005
	12		30. Name and address of person	Completed car	ise of death /	Item 23a) (Typo				1149 US	- 44	, 2005
			Joseph Kap					r Oln	ev. MD	20832		
	Sta	_	31. Date filed (Month, Day, Year)	38.1	Registrar's Si	gnature	_	0411	-11 MD	0002		
	Registr	ar	AUG 30	2005	STATE OF	gradure Br. Age						

			1- For Amend Item 2944 per Mary 3084 per Mar	म् राह्यकृत्रा ख्याति and M rtificate of Death	ental Hyg F	gien 2005	30018
			Decedent's Name (First, Middle, Last)		2. Date of Dea Month	ath Day Year	3. Time of Death
	Physicia /Medic		Lawrence Wade Woolford		August	27, 2005	9:30 a. M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	th
			12026 Walnut Point Road	Hagerstown		Washing	ton
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birti (Month, Day	h 9. Bir y, Year) C	thplace (State or Foreign ountry)
	Director		705–12–6278 ¹ X 2□F 88 Yrs.		October	20, 1916	WV
	pur 💃	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li	ocation			10d. Inside City Limits
	aho	ō		1			1 TYYes 2 No
	280-1	Director	MD Washington Hancoc	10f. Zip Code		10g. Citizen of What C	ountry?
	with ta or		129 Limestone Road	21750		USA	
	death with the Maryland me 23a or 28e-f show	Funerai	11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - Am	
0	riter	필	Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☒ No	If Yes, specify Cuban, Mexican, Puerto I	Rican, etc.)	Black, Whi	te, etc.
215-0036	be filed within 72 hours after death with the Marylan tal Hygiene. Ind other then "natural", or items 23s or 28e-1 show event, the Macinal Examination of the collision.	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify:	√hite
ָה מ	72 hc	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of workir	ng	16b. Kind of Business	/Industry
7	within 72 ene. then "na!	du	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			
7	filed w Hygier other th			Maintenance 18. Mother's Name	/First Middle	Railroad	
מש	be filed ntal Hygid od other event, II	Be	17. Father's Name (First, Middle, Last)			Maldell Sullame)	
Maryland	should be nd Mental marked o	٩	John M. Woolford 19a. Informant's Name/Relationship (Type, Print) 19b. Maili	Ruth Amb		or City or Town State	Zin Code)
<u>Z</u>	d 2 sho thand 7 is m traum			-			
	is 1 and 2 should of Health and Mer item 27 is marke other traumatic	1	20a Method of Disposition 20b. Place of Disp		ate na er	20c. Location - City or	
2	Pages nent of nnt: If it iry or o		1 Burial 2 Cremation 3 Hemoval from State	Compo to access	VOE T	Sander Laur Co	177
Baltimore,	artme orten injur		Brechway	Cemetery 08/30 2. Name and Address of Facility		Berkeley Sp	
ñ	permit. Pages 1 Department of H Importent: If itel any injury or ott	-	er Grode Gr	ove Funeral Home,	P.A Har	West Main	750-0368
1000			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only end cause on each line.	iter the mode of dying, such as cardiac o	r respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final	-ancer			Onset and Death
1	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	i t ti	1	120.0	
	Examiner		Commodially list and disings	obstructive	e h	Disease	
	n =	ner	if any, leading to immediate Due to (or as a consequence of):				
	scute ind trans	Examin	that initiated events c.				
20,	oe execian a		resulting in death) Last Due to (or as a consequence of):				
8760	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d				
×	ding	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of de	livery
. Box	atten for u	cian	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
<u>о</u> .	that the death certifi ed by the attending detached for use as	ysi	1 Yes 2 No 9 Unknown				
٠. ت	es that igned b	by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
g	w require been sig should b	pe			101	res 2□No 3□P	robably 4 Honknown
ပ္တ	aw ress bee	Completed			24a. Was	an 24b. Were a	utopsy findings available completion of cause of
ž	The law cate has page 2:	E			perfo	rmed2/ death?	2 □ No
Vital Records,	sicien: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?	26. Place of Death	(Check only o	one)	f Paradatau
<u></u>	Physic this ce al dire	10	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie			dence 6 10 Other (Spe	f Daughtor
0	Jing P	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury	Work?	28d. Describe h	now injury occurred	
Sio	tendi leath. Ior: A	cati	2 Accident investigation	M 1 Yes 2 No	Ont I posting /f	Carron and Museum and C	lural Davida Maresha s
Division of	i or Attend after death Director: /	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	treet, factory, office	City or Tov	Street and Number or R vn, State)	urai Houte Number,
	poital purs a leral filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, a	and due to the	cause(s) and manner a	s stated.
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurre	ed at the time,	date and place, and du	e to the cause(s)
	To th Within To th	Me	29b. Signature and Menof certifier	29c. License number	/	29d. Date signed (Mon	
}			tand mining	5,006039	6 .	August 29,2	CUUS
	6		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) 1126 00	a	c	119/14
			EALLO WALLSHED	Hage	25. LOM	NWD	21740
k,	Sta Regist		31. Date filed (Month, Day Year) SEP 1 3 2005				

State of Maryland / Department of Health and Mental Hygien 2005 30019 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month **Physician** AUGUST 24 2005 11:13 A^M HARRY DANIEL WIGGINS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner STEVENSVILLE QUEEN ANNE'S 327 QUEEN ANNE ROAD If Under 1 Year If Under 24 Hrs. Min. 8. Date of Birth (Month, Day, Yeer)

AUG. 23, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months 1 X M 2 □ F Yrs. 1931 MD Director 212-26-0138 74 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State s 23e or 28a-f shor 1 ☐ Yes 2 X No Director QUEEN ANNE'S STEVENSVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 21666 USA 327 QUEEN ANNE ROAD Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 X No Specify. þ 3 Widowed 4 ☐ Divorced neturel Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry treumetic event, the Madical 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ ASSISTANT GENERAL SUPERVISOR ELECTRIC AND GAS 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be DANIEL G. WIGGINS CLARA HALLOCK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is eny injury or other tre once. 1510 WHITE TAIL DEER CT., ANNAPOLIS, MD MICHAEL WIGGINS/SON 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CENTER, LLC. 08/26/2005 * 4 □ Donation 5 □ Other (Specify) STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, attending physician Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? ignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 1 ☐ Yes 21 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 5 Residence 6 Other (Specify) Certification: To this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. after death Director: / d in by the f 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours 2 🔀 crtifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 ☐ Medical Exemine To the within 2 To the 29d. Dale signed (Month, Dey, Year) License number 29b. Signature and the death (Item 23a), (Type, Pring 10 32. Registrar's Signature State Registrar

			For State Registrar	State of M	aryland / Depa	artment of H		lental Hygi	ene g. No.2005	30020
	Physici /Medic		1. Decedent's Name (First, Middle, La Orrie Mae	_{st)} Webb				2. Date of Death Month	25, 2005	3. Time of Death
	Examin		4a. Facility Name (If not institution, giv Solomons Nursir 5. Social Security Number 6. S	g Center	ge (In yrs. last birthday)	4b. City, Town, or Solomo	Location of Death ONS If Under 24 Hrs.	8. Date of Birth	4c. County of Deat	
	Funeral Director		577-28-8529 Usual Residence of Decedent		33 Yrs.	Months Days	Hours Min.	Dec. 10,	1921 Was	hplace (State or Foreign untry) hington DC
	ath with the Marylan s 23e or 28e-f show	Director	Maryland Calvert 10b. County Calvert		10c. City, Town or Lo	gtown			000	10d. Inside City Limits 1 ☐ Yes 2 📉 No
	3e or 3	Dic	1623 Dartmoor Dri	VP		10f. Zip Code 206	30	10	g. Citizen of What Co USA	untry?
980	d within 72 hours after death with the Maryland liene. r than "netural" or Items 23e or 28e-f show the Medical Exaction routite nutified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No		ispanic Origin? (Spann, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	within 72 ho ene. than "netur	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or	(Give 5+)	DO NOT use retired	during most of work	ing 1	6b. Kind of Business/	
d 2	Hyg Hyg Stha ant,	0	17. Father's Name (First, Middle, Last)	П	omemaker	18. Mother's Name	e (First, Middle, M.	Own H	ome
ylar		ToB	George W. Sterlin	*				y Handle		
Maryland	12 s h ar 7 is		19a. Informant's Name/Relationship (Lea A. Mulligan -		1				City or Town, State, 2	urrest.
	Pages 1 and nent of Healt int: If itam 2' iry or other i		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, crei	sition (Name of natory or other plac	(9)	Date 2	In MD 206:	Town, State
Baltimore,	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Special 21. Signaru) e of Funeral Service Lice		00053 22	Memorial 2. Name and Addres Huntt Fune		P. 0	Maldorf, M Box 156 orf, MD 20	
	_ 11 1		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each li	d the death. Do not ent					Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. CERE	BROVAS	CULAR	Acci	FT		Onset and Death
,00	Examiner	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	b. ATHER Due to to, as	a consequence of): a consequence of): a consequence of):	c (AR)	uVASCUL.	ar Di.) = 43 [YEAR
.O. Box 68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
<u>α</u>	w requires that been signed b should be deta	by	Part II. Other significant conditions of		DEMF~7		en in Part I.		2 No 3 Pro	the cause of death?
Il Records,	The ate h page	Completed						24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of
Vital	Physician: This certifical	o Be	25. Was case referred to medical examiner?	- Hospital: 1	ent 2 ER/Outpatier	it 3□ DOA Othe	26. Place of Death		ce 6 □Other (Spec	
ion of		Η.	27. Manner of Death 1 Matural 5 Pending 2 Accident investigatio	28a. Date of Inju (Month, Da		28c. Injury Work		28d. Describe how		
Division		Certification;	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of in	jury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To tha Hospital or within 24 hours after or the Funaral Director completely filled in the funaral or the funaral Director or the funaral Director or the funaral or the fun	ledical	(Check only 2 Medical Example)	nysicien: To the best miner: On the basis of and manner st	of my knowledge, deatl of examination and/or in ated.	vestigation, in my op	oinion, death occurr	ed at the time, dat	e and place, and due	to the cause(s)
	T with	Σ	29b. Signature and title of certifier			29c. License			d. Date signed (Month	
î			30. Name and address of person who	completed cause of	death (Item 23a) (Type,	Print)	0338		+00001	01 2001
1	810		178HN H	WEIG	FL, M)	-PRI	uce f	REJER	1CK M.D	2 F 2007 - 20678
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 6 2	2005	w & A	berk				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2005 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** 24, 2005 12:10p^M August Ronald Weir /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Ceci1 Sunbridge Care E1kton 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F Months 1947 Director 178-36-2727 December Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show itsm 27 is marked other than "natural", or Items 23a or 28a-1 sho other traumatic event, I've Medical Examinar must be notified at 1 ☐ Yes - No Director Cecil Elkton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 49 Cox Lane U.S.A. 21921 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. tyE Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Vietnam 3 Widowed Divorced Era 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction Mason 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental ! George Weir 2 Laura Rineer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itsm 27 l 49 Cox Lane, Elkton, MD Terry Day/Guardian 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If its any injury or of 20059. 1 🔀 Burial 2 □ Cremation 3 □ Removal from State ` 4 ☐Donation 5 ☐ Other (Specify) Elkton Cemetery | August 30, 2005 21. Signature 191 e of Service Licensee 22. Name and Address of Facility Andrew G. Gee Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21921 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnemonia **Physician** unk /Medical Due to (or as a consequence of): **Examiner** UNK Carconon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner inding physicien and use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed JUL Metrice to N that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 🗌 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Xo 1 🔲 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending М 1 TYes death. investigation 2 Accident the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) with n 24 hours after o To the Funeral Direct in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier dica (Check only onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8125/05 D04823 Our ceiple MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21921 Elkton MD 223 W Hsu 31. Date filed (Month, Day Year) 2 9 2005 State Registrar

		I.	State of Maryland / Department of He 1- For State Recistrar Certificate of D) 4h	giene Reg. No. 2005	30022
			Decedent's Name (First, Middle, Last)	2. Date of De		3. Time of Death
	Physicia /Medic	al	Marsorie Whitten	Cuyu	st 22,200	
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Shady Grove Adventist Hospital Rocky:		4c. County of Dea	
	Funeral		5 Social Security Number 6, Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs. 9 Date of Bir	Montgo	thplace (State or Foreign
	Funeral Director		185-12-7385 1 M X F 84 Yrs. Months Days	Hours Min. (Month, Da Dec. 7,		
	pug 🔺		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Maryla f sho	Į.	MD Montgomery Silver Spring			X⊠Yes 2□No
	r 28a	lrec	10e, Street and Number 10f. Zip Code		10g. Citizen of What Co	ountry?
	23e c	ral	2921 N. Leisure World Blvd #417 2090		U.S.A.	The state of the s
	er des	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	spanic Origin? (Specify Yes or No n, Mexican, Puerto Rican, etc.)	14. Race - Ame Black, Whit	
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2-0	72 hours after death with the Maryland neturel; or Items 23e or 28e-f show oteal Exaculter court be collified at	Completed by Funeral Director	15. Decedent's Education 16a. Decedent's Usual Occupa (Specify only highest grade completed) (Give kind of work done di	uring most of working	16b. Kind of Business	/Industry
2	vithin ne. hen "	mple	Elementary/Secondary (0-12) College (1-4or 5+))	Talida	т
d 2	filed v Hygie other t	CO	12th Supervisor 17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle	Holiday , Maiden Surname)	inn
lan	itd be fental rked o	To Be	Mett Yancey	Helen Br	own	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importment if time 27 is marked other than "neturel; or Items 23e or 28e-f show any injury or other treumatic event, It's Madical Examination unit be notified at once.			and Number or Rural Route Numb		
_``	fealth m 27		Carol Portis - Daughter 2921 N. Leis 20a. Method of Disposition (Name of	sure World Bl	20c. Location - City or	
nor	ages nt of H		1X Burial 2 □ Cremation 3 □ Removal from State 1X Burial 2 □ Cremation 3 □ Removal from State 1X □ Donation 5 □ Other (Specify) Gate of Heaven	8/27/05	Silver S	
Baltimore,	artme	1		s of Facility Snowden		
ä	permit Depar Impor any ir		The state of the s	Washington St		e,MD20850
*			23a. Part1. Enter the disease, or complications that caused the death. On not enter the mode of dying shock, or heart failure. List only one cause on each line.	g, such as cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Priysician	Q. II	Immediate Cause (Final disease or condition resulting in death) a	ry Failur	2	minutes
	/Medical Examiner		V.	9		Ween
	-28	Jer	Sequentially list conditions, any loading unique list. Due to (or is a consequence of):			Up 6 res
	ocuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Prodetes mellitude Due to (or as a consequence of):	S		-) CO(13
8760,	death certificate be executed e attending physician and ad for use as the burial-transit		resulting in death) Last Due to (or as a consequence of):			
687	ficate physics the l	edicai	d			
Box	leath certific attending p	M/U	IF FEMALE: 23b. Was decedent pregnant 1		23d. Date of de	
O. B	e deat the atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ Yoo 9 ☐ Unknown 1 ☐ Unknown		Month	Day Year
σ.	law requires that the de as been signed by the a 2 should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I. 23e. Did	tobacco use contribute t	o the cause of death?
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Vital Records,	aw require is been si 2 should b	Completed		24a. Was	an 24b. Were a	utopsy findings available completion of cause of
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ion	Attending I r death. ector: After by the funer	atlor	2 Accident investigation M 1 1	Yes 2 □ No		
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Ω	To the Hospitel or within 24 hours after To the Funerel Director Completely filled in E		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time	ne, date and place, and due to the	cause(s) and manner a	s stated.
	To the Hospitel within 24 hours of To the Funeral I completely filled	edical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my open and manner stated.	pinion, death occurred at the time	date and place, and du	e to the cause(s)
	To the within To the Comp	ĕ	29b. Signature and title of certifier 29c. License	number	29d. Date signed (Mon	th, Day, Year)
	4		Ochoraly hemsemp 1036		august ?	3005
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debugah J Shevyi I no 9901 Medical Ce	ntern Rr	Icu'lla ma	20850
	Sta	ate	31. Date filed (Worth, Day, 16a)	-1.1.5 101 11 00	1-01111 11.00	,
	Regist	rar	AUG 2 6 2005 Some S. Aparte			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Charles Murray Yost August 25 2005 5:00 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 133 Church Road Arnold Anne Arundel If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1**⊠**M 2□ F 216-16-9906 84 Director Jan. 1921 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County rel', or items 23a or 28a-f show Examiner a ust be notified at 10d. Inside City Limits Maryland Anne Arundel Arnold 1 Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 133 Church Road 21012 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decided and Market Porces?

1 R Yes 2 No
If Yes, Give
Year or Dates:
1042-104
| 16a. 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced "neturel" white Completed The Medical 15. Decedent's Education (Specify only highest grade completed) ecedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Director Department of Health other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth eny liquy or other treumatic event 900g. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Charles Frederick Yost Florence Marie Phillip

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) George Sharkins / friend 1312 Jones Station Rd. Arnold, MD 21012
Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 8-31-05 * 4 ☐ Donation 5 ☐ Other (Specify) BAltimore, MD Baltimore Crematory
22. Name and Address of Facility John M. Taylor Funeral Home, 21. Signature of Fugeral Service Licensee Koman 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) melas **Physician** tale /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed the burial-transit ding physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month 4☐ Pregnant at time of death signed by the all 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 28 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Sesidence 6 Other (Specify) P 1 ☐ Yes 2 🔀 👀 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Mann of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C ertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 07 53306 246 rson who completed cause of death (Item 23a) (Type, Print) Ed Ste 300 Annapoles MD 21401

State Registrar 31. Date filed (Mor

DHMH 17 Rev 1/2001

(41)

900 32 Registrar's Signature

30024 State of Maryland / Department of Health and Mental Hygiene 005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician TUDE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Allegany Cumberland Lions Manor Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1 ☐ M 2 🖫 F Yrs Oct 14. 484-36-2469 87 1917 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other treumatic event, the Medical Examiner must be notified at MD Allegany Cumberland 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 901 Seton Drive 21502 USA or Items 23a Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after ☐Yes 2☐No f Yes, Give X 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white 3 XVidowed 4 Divorced Year or Dates: "netural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than any injury or other treumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be Elizabeth Jensen Manz Walter Manz 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 600 Washington Street Cumberland MD 21502 Garv Cook son-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Shelby Cemetery, Shelby, Iowa 9/12/2005 IA Shelby 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 21. Signature of Funeral Service License 108 Virginia Avenue; Cumberland, MD 21502 Part. Inter the disease, or complication shock or heart failure. List only one cau Approximate Interval Between Onset and Death s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** But disease or condition resulting in death) NEUMONIA 10 /Medical Due to (or as a consequence of): Examiner YEAR TROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed burial-trans and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2000 3 ☐ Probably 4 ☐ Unknown NEARCT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas director, page 2: autopsy certificate 21 No 1 Yes Be 26. Place of Death (Check only one) 25. Was case referred to medical examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitel 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DEPTEMBER 8 2005

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

P.O. Box 68760.

Division of Vital Records,

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

912 Seton Drive Cumberland MD 21502 Gregg Donaldson M.D.
Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen 30025 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 26, 2005 Year Anna Marie Zecher 12:25 p M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Chesapeake Hospice House Linthicum Anne Arundel 8. Date of Birth (Month, Day, Year) Country)
Tune 16, 1923 Washington, D.C. If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 578-22-5505 1 □ M 2 1 F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Bladensburg 1⊠Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20710 4108 53rd Avenue, Apt. #3 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3

☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lee's Tavern Cashier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Francis Poore Mary Virginia Beavers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jo Anne Flood-Daughter 11886 Royal Tee Circle, Cape Coral, Florida, 33991 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 8/27/2005 Alexandria, Virginia Metropolitan Crematory 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 21. Signature of Funeral Service Licenses laudette Dasch - danning 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dru gr Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 ☐ Unknowi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 20 HB FILE ESIDENCE 2. No 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death 28b. Time of Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 / Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License numbe 21438 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 445 Defense Highway, Annapolis, MD Michael LaPenta, M.D. 32. Registrar's Signatur

State Registrar

Physician

/Medical

Examiner

Director

à

Completed

Funeral

Director

in then "natural", or Items 23a or 28a-f show the Medical Exempler must be notified at

is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other then "natural, or ite other traumatic event, the Medical Experiment.

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Pnysician /Medical Examiner

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certificate

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After

Director: A

Hospital or Attending Physician:

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The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examine

Physician/Medical

2

Completed

Be

Certification:

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Baltimore, Maryland 21215-0036

with the Maryland

death

30026 State of Maryland / Department of Health and Mental Hygier $\bigcirc \bigcirc \bigcirc$ For State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 6.047 M 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bond Washington Medical Xn Kmmit 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) 6. Sex Social Security Number **Funeral** 18M 2□F 219-38-040 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State County 27 is marked other than "natural", or Items 23e or 28a-1 show treumatic evant, Ite Mcdical Examinar in ust be notified at ANNE 1 ☐ Yes 2 No ARUNDE Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. Int: If itam 27 is marked other than "natural", or Items 23 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ONSTRUCTION 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) HARRY FOSTER AUTRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health ar Important: if itam 27 is any injury or other treaconce. DIANA DR. WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 @Cremation 3 ☐ Removal from State VIEW CREMATORY 4 □ Donation 5 □ Other (Specify) 21. Signatu s f Fundral Gervice Licens Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death S Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque ce of): Examiner use as the burial-transit Due to (or as a consequence of) ed by the attending physician detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown certificate has been signed by rector, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 ENO 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 TYes 25 No Hospitel or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 2 No 1 🗌 Yes 1º Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 28d. Describe how injury occurred Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a rest Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the within 2 To the 29d. Dafe signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 0 0 31. Date filed (Month Day Year) 32. Registrar's Signature State

Registrar

			For State Registrar		Sta	ate of N	Marylar		artmeni rtificate				ental Hy	giene Reg. No.	7 11 11 5	3	0027
			Decedent's Name	(First, Middle	e, Last)								2. Date of De			3.	Time of Death
	Physici /Medic		Annette	e Mary	Eliza	beth	Amato)					Septemb		13 2005	1	1:20 PM
	Examin	er	4a. Facility Name (If		-						Location	of Death			County of Dea		
	- A-+	1. The state of th	Gilchr: 5. Social Security Nu		spice 6. Sex			last birthday)	Tows		If Under	24 Hrs. i	9 Date of Bir		Baltimo		/C+-+
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Balti	permit. Pages Department of H Important: If Ite any Injury or of		21. Signature of Fur			M	niuu-	2 41	2. Name an	d Addres	s of Facili	™Harı	ry H. W	itzk	e's Fan City,	uly MD 1	FH Inc.
	- 3		23a. Part1. Enter the shock, or hear	e disease, or	complication	s that caus	sed the dea								CICY,	Appr	roximate
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	MH 17 Rev 1/2																

Amato, Annette 9-13-05 1120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item, 8 per fb r847, 9-28-05 yt

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amin	er	4a. Facility Name (If not institution		•	.1	1	y, Town, or umbia		f Death			c. County	_	
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		Usual Residence of Decedent								05 05			100110	ab City/i
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			For State Registrar	state of Maryland	Q \ b)	epartment of Certificate o	Health and I f Death		giene Reg. No.	005	30029
			Decedent's Name (First, Middle, Last)		7			2. Date of De	ath		3. Time of Death
	ysicia Medic		William J	Bar tos	7	<u>(</u>		Month 09	Day Oq	2005	
	amin	40.00	4a. Facility Name (If not institution, give stre		4		, or Location of Deat	n	4c.	County of Dea	
Eur	eral		5. Social Security Number 6. Sex	Tand Medical 7. Age (In yrs. 12		day) If Under 1 Yes		8. Date of Bir	th	0.8	
Dire			212-54-7396	^{2□ F} 55	Υ	rs. Months Day	s Hours Min.	Jan. 26	, 1950	Ma	rthplace (State or Foreign Country) ryland
and	5		Usual Residence of Decedent 10a, State 10b, County	10c. City	Town	or Location					10d. Inside City Limits
Maryl:	Beda	to	Maryland Anne Aru			sadena					1 Yes 2 No
h the	noti	Director	10e. Street and Number			10f. Zip Code	9		10g. Citiz	en of What C	country?
ath wit	ustra	raiD	8425 Garden Road			23	1122			U.S.A	•
C 6 12 13-0000 filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-1 show	other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑Divorced	Was Decedent Ever in U.\$ Armed Forces? 1 ☑Yes 2 □ No If Yes, Give 1968- Year or Dates:		13. Was Decedent of If Yes, specify Co	of Hispanic Origin? (Suban, Mexican, Puerlo Jo Specify:	pecify Yes or No o Rican, etc.)		Black, Whi	erican Indian, ite, etc. hite
72 h	dical	etec	15. Decedent's Educat (Specify only highest grade of	on ompleted)	16a. [Decedent's Usual Occ 'Give kind of work don life. DO NOT use reti	cupation ne during most of wo	rking	16b. Kir	nd of Business	s/Industry
within ene.	No Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Pipefiti			II.	S. Coa	st Guard
filed Hygin	/ent, I	a)	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,			oudi d
Z should be filed withing and Mental Hygiene. Is marked other than	atic e	To B	William J.	Bartos Sr.			P	auline		Unkown	
12 sho	raum		19a. Informant's Name/Relationship (Type,			Mailing Address (Stre					(1)
C, IV 1 and Health Health	ther		Donna J. Legge (I	riend)	ace of I	05 Parksion (Name of		Pasadena Date		ryland ation - City or	
partificies, INC permit. Pages 1 and 2 : Department of Health ar Important: If Item 27 Is	jury or c		1 d Burial 2 □ Cremation 3 □ Rem '4 □ Donation 5 □ Other (Specify)	oval from State Cro	ometery Owns	crematory or other postile VA (Cem. 09-1	6-2005			e,Maryland
Depart	any ir		21. Signature of Bineral Service License	amull		McCully-I 3204 Moui	Polyniak F itain Road	uneral H ,Pasader	Home na, M	P.A arylan	d 21122
	,		23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one of	ions that caused the death cause on each line.	. Do no	ot enter the mode of d	tying, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
Physic /Med			Infriediate Cause (Final disease or condition resulting in death)	Hente par	1EVR	atitis					2 2045
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ecute	-trans	Examiner	Cause (Disease or injury that initiated events c resulting in death) Last	Due to (or as a consequ		No.					
be ex	as the burial-transit	alE		Due to (or as a consequ	erice oi).					
ificate g physi		edical	d								
DIVISION OF VITAL INCOURUS, T.O. DOX 00 100, 7 or To this Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page 2 should be detached for use :	Physician/M	IF FEMALE: 23c. 23c. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death	3 ☐Ectopic pregnar 5 ☐ Other (specify)			2	3d. Date of de Month	olivery Day Year
9, 7 es that igned b	e deta	by Pt	Part II. Other significant conditions contrib	outing to death but not resu	Iting in	the underlying cause	given in Part I.	23e. Did t	obacco us	e contribute t	o the cause of death?
require sen sig	pluo							1 🗆 '	Yes 2	No 3□P	robably 4 Unknown
The law ate has by	page 2 st	Completed						24a. Was autor perfo 1 Yes		24b. Were a prior to death?	
ician:	ector,	Be	25. Was case referred to medical examiner?	oital: 1.C				th (Check only o	$\overline{}$		
Phys	ral dir	5	19163 2010	Dital: Inpatient 2 ☐ 8 28a. Date of Injury	PVOutp 28b. Tii	Dallerit 3 DOA		ome 5 Resident			ecify)
nding Phy th: :: After thi	e fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)		ury V	vork? □Yes 2□No	200. 0 630.100 1	10 W III III II	00001160	
l or Atter	d in by th	Certification:	3 Suicido 6 Could not be	28e. Place of Injury - At hor building, etc. (Specify,	me, farr	n, street, factory, offic	ce ce	28f. Location (: City or Tox	Street and vn. State)	Number or R	ural Route Number,
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After	etely fillec	edical C	29a. Certifier (Check only one) Certifying Physici (Check only one)	an: To the best of my know: On the basis of examinati and manner stated.	vledge, ion and	death occurred at the for investigation, in my	time, date and place y opinion, death occu	, and due to the rred at the time,	cause(s) a	and manner a place, and du	s stated. e to the cause(s)
To the within To the	сошр	Me	29b. Signature and hille of certifier	1 0		29c. Lice	nse number		29d. Date	signed (Mon	th. Day, Year)
			, OV MUSIN	W		AUYIT	7643551	5802	-Se	pt 1	0 2005
_ (,	X		30. Name and address of person who comp	leted cause of death (Item South Gre	23a) (T	Von Brint)			MD	21	201
Re	Sta egistr	15.000	31. Date filed (Month, Day, Year) SEP 1 5 2005	South Gre	уге	parte					-

State of Maryland / Department of Health and Mental Hygiene 2005 30030 1 - For State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 1 2005 **Physician** EVELYN BLUM 7:00 A LORRAINE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1722 PATAPSCO STREET BALTIMORE 8. Date of Birth (Month, Day, Year) Aug. 26 1927 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🗑 F 88 Director Maryland 220-12-6344 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or iteme 23a or 28e-f show other traumatic event, the Medical Exam are must be notified at n/a Md. Baltimore 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1722 Patapsco Street 21230 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be fil ment of Health and Mental H ant: If Item 27 Is marked ott Hilda Abbott Claire Franks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau once. 1722 Patapsco Street, Baltimore, Md. 21230 (Son) Charles L. Blum 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 09/14/05 Baltimore, Md. Cedar Hill Cemetery 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
130 E. Fort Ave., Baltimore, Mid. 2 21. Signature of Funeral Service License 21230 mux th1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest nock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Injurediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner buriai-transi resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Completed by Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) bed 1 Ö 9 Unknown 9 Unknown signed by the Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 2 No 1 Tes 2 No 1 Tyes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manne of Death 1 Natural 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? Certification: After Attending 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the f 2 Accident after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier are M.D Hospital Drine, Glen Sum 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ~ 305 32. Registrar's signature 31. Date filed (Month Day, Year) State Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** A^{M} 9-13-2005 Barbara M. Butschky 4:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 168 Burns Crossing Road Severn Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Yrs. 212-28-7806 Director 90 12-25-1914 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits worde! r than "naturel", or items 23s or 28s-f show the Madical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 168 Burns Crossing Road 21144 U.S.A. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 21 No Specify: White Completed by 3

Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing nd 2 should be filed vilth and Mental Hygie 27 le marked other in traumatic event, its 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles G. Schmidt Mary Zuddlemeyer 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Importent: If Item 27 le. eny Injury or other trau Mrs. Barbara Buck / Daughter 168 Burns Crossing Road; Severn, MD 21144 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 15 Burial 2 Cremation 3 P 4 Donation 50 Specify) 3 Removal from State Loudon Park Cemetery 9-16-2005 Baltimore, MD 21. Signature 22. Name and Address of Facility Singleton Funeral Home PA ice License 1 Second Ave. SW; Glen Burnie, MD 401411 base, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. 23a, Part . Enter the d Approximate Interval Between shack, or heart and Immediate Cause (Final disease or condition resulting in death) Physician ncoma a /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical use as attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a o 9 Unknown 9 Unknown σ. ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No 1 Yes Division of Vital : After this certification of the thick the th Be 25. Was case referred to medical examiner? 26. Place of Death |Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Sidence 6 ☐ Other (Specify) ۵ 1 ☐ Yes 2 ☑ No 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred To the Hospital or Attending 1 Matural 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier and manner stated. 29b. Signature and title of certifier Hospital Dr. Gles Burnie. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) kan wollhish 31. Date filed (Month, Day, Year) SEP 1 32. Registrar's Signature State 2005 Registrar

Physic	an	Burman State of Mary State of Mary State Amend Item & Unpend Item RegistreAMEND ITEM #17&19a PER Decedent's Name (First, Middle, Last)			2. Date of Month	Death Day	Year	3. Time of Death
/Medi	al .	JONATHAN Jonathon Lloyd But a. Facility Name (If not institution, give street and number)		BURMAN-			03 2005 County of Death	21:32 P
Examir	er		<u> </u>		or Death	40.		I/A
Funeral		3714 Cottage Ave. Social Security Number 6. Sex 7. Age (In.	vrs. last birthday)	Baltimore If Under 1 Year If Under	24 Hrs. 8. Date of	Birth		place (State or Fore
Director		214-92-6542 1M 2 F Isual Residence of Decedent	28 Yrs.	Months Days Hours	Min. 8. Date of (Month, 09/30)	/1976		MD MD
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28a-f	Director	Oe. Street and Number	DALTINO	10f. Zip Code		10g. Citi	zen of What Cou	
23a or 28a si be roti	D	6514 EBERLE DRIVE APT. #101		21215			J.S.A.	
el', or tems 23s or 28s-f elvo Examiner must be notified at	by Funeral	1. Marital Status 1. Marrital Status 1. Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		s Decedent of Hispanic Or 'es, specify Cuban, Mexica Yes 2 No Specify			14. Race - Ameri Black, White	ican Indian, etc. ITE
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of Health and Ment of Health and Ment filem 27 ie marked r other traumatice		19a. Informant's Name/Relationship (Type, Print) ANN WELHAM / MOTHER	1	Address (Street and Numb				
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ages ant of t: If it y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crema ALTIMORE I	tory or other place)	9/14/2005 09/09/2005		ΓΙΜΟRE,	
Department of Important: If i any Injury or of once.		21. Signature of Funeral Service Licensee	22. 1	Name and Address of Facil	SOL LEVI	NSON 8	BROS.,	INC.
20240		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	189(O REISTERST	OWN ROAD -	PIKES	SVILLE,	MD 21208 Approximate
ysicien and will transit on burial-transit on	cal Examiner	Sequentially list conditions, f any, leading to immediate ause. Enter Underlying Cause (Disease or injury hait initiated events esulting in death) Last b. Due to (or as a cor						
eath certificate attending physical for use as the		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of profile in the past 12 months?		ctopic pregnancy		2	23d. Date of deliv	very Day Year
ed by the at detached fo	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnent at time 9 ☐ Unknown	of death 5 C	Other (specify)		-	worter.	Day
n signed by uld be detac	ed by Pt	art II. Other significant conditions contributing to death but no	t resulting in the und	erlying cause given in Part		d tobacco u □Yes 2[the cause of death
To the Thospital by Atlanting Frightien; The taw requires that the beautivest within 24 hours after death. within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med				_ ≠ pe	as an itopsy informed? s 2 \(\sqrt{No}	24b. Were autoprior to codeath?	opsy findings avail omptetion of cause 2 \(\text{No} \)
certif	9 Be	25. Was case referred to medical examiner? 1 (¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬	م المال	05	e of Death (Check onl		Mou to	
th. :: After this e funeral d	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28b. Time of Injury 8:00	28c. Injury at Work? M 1 Yes 2 X	ursing Home 5 Re 28d. Describ		6 ∭Other (Speci y occurred U	ink Scene
within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ★ Could not be determined 6 ★ Could not be determined 28e. Place of Injury. building, etc. (St. found in fi	found At home, farm, stree becity) nouse	P factory, office			3714 Co Maryland	al Route Number, ottage Av l
24 hours after of Funerel Directory Stely filled in	Medical	29a. Certiflier (Check only one) 1 ☐ Certifying Physician: To the best of my and manner stated.	knowledge, death omination and/or inve	occurred at the time, date as stigation, in my opinion, de	nd place, and due to the time	ne cause(s) ie, date and	and manner as s place, and due t	stated. to the cause(s)
within 2 To the comple	Mec	29b. Signature and title of certifier	*	29c. License number			e signed (Month,	
		· VM. /x		O.C.M.E.		Sept	ember 04	4, 2005
10k pand								

		1 - For State Registrar	State of Marylar	nd / Department of Certificate				5 3003
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Las Alyssa Brown 4a. Facility Name (If not institution, give	,	4b. City, To	wn, or Location of Death	2. Date of Death Month Septemb	Day Year Year 4c. County of De	5 5:021
Funeral Director		5. Social Security Number 6. Se			Year If Under 24 Hrs. Pays Hours Min. 2 6	8. Date of Birth (Month, Day,) Sept 7,		Birthplace (State or Foreig Country) aryland
within 72 hours after death with the Maryland ene. Han "natural", or Items 23a or 28a-f show the Madical Examinar must be reditied at the Madical Examinar must be reditied at the Madical Examinar must be reditied.	Director	10a. State 10b. County MD Baltimo 10e. Street and Number 2414 Bridgehampto	ore	Baltimore 10f. Zip Co	ode 21234	100	j. Citizen of What USA	10d. Inside City Limit 1 ☐ Yes 2√ N Country?
ges 1 and 2 should be filed within 72 hours after death with the Marylan ges 1 and 2 should be filed the filed the filed Marial Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	J.S. 13. Was Decedent If Yes, specify	t of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecrfy Yes or No- Rican, etc.)		nerican Indian, nite, etc. black
High within 72 nd Hygiene. Ather than "natur ant, the Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) NONE	ucation de completed) College (1-4or 5+) NONE	16a. Decedent's Usual O (Give kind of work of life. DO NOT use r	tone during most of work	ing 16	sb. Kind of Busines	ss/Industry
2 should be filed and Mental Hygis Is marked other Bumatic event, I	To Be (17. Father's Name (First, Middle, Last) Alphonso Brown 19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mailing Address (S	Sheen	a Scott al Route Number, (, Zip Code)
permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trei		Franklin Square 20a. Method of Disposition 1 Burial 2 Cremation 3 '4 Donation 5 Other (Specify,	20b. I Removal from State	er 9000 Frank Place of Disposition (Name of commetery, crematory or other	of I	-	sedale, M	
permit. Pa Departmer Important any injury once.		21. Signature of Funeral Swice Licens Ronald S.	Wade Virector	Baltimor		1		Street
sicie sicie	licai Examiner	23a. Part 1. Enter the disease, for comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect d. Due to (or as a conse	quence of): The Convergence of	npetent	- Cerv	/iX	Approximate Interval Between Onset and Death
ate has been signed by the attending physic page 2 should be detached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3 ⊟Ectopic pregn			23d. Date of d Month	elivery Day Year
been signed be should be deta	۾	Part II. Other significant conditions co	ntributing to death but not res	sulting in the underlying caus	e given in Part I.	23e. Did tobac	~	to the cause of death? Probably 4 Unknown
is certificate has be director, page 2 sh	e Completed	25. Was case referred to medical			26. Place of Death	24a. Was an autopsy performe	d? prior to	autopsy findings availal completion of cause of s 2 No
0 0	ation; To B	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 VInpatient 2 2 28a. Date of Injury (Month, Day Year)	28b. Time of 28c.	Other: 4 Nursing Ho	me 5 Residence 28d. Describe how		ecity)
urs after de ral Directo	Certification;	3 Suicide 6 Could not be determined	building, etc. (Special			City or Town, S	State)	Rural Route Number,
to the mobile or executing rivering the within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	sician: To the best of my knotiner: On the basis of examina and manner stated.	ation and/or investigation, in i	ne time, date and place, any opinion, death occurrencense number	ed at the time, date	se(s) and manner a and place, and du	nth, Day, Year)
Stat Registra		30. Name and address of person who could be a seried (Month, Day, Year) SEP 1 5 2005	ompleted cause of death (Iter USSU 9000 32. Registrar's Signa	Franklin So	war Dru	e Baltu	More Ma	12/237

Ryan Burch 05-6202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

d]	L		1 - State Unpend Item	State of N	Marylan 8a-f	d / Depa	artment of H	lealth	and M	ental Hygi	ene 2005	30034
			1. Decedent's Name (First, Middle, La		.Oa 1	per me	THEATE OF	Эеан	n cas	2. Date of Death	g. No.	3. Time of Death
	Physici	an								Month	Day Year	м
	/Medio Examir		Ryan Christopher 4a. Facility Name (If not institution, gi		r)		4b. City, Town, o	r Location		Septembe	r 10, 200 4c. County of Dea	
	Exami	eı	Howard County Ger				Columbia				Howard	
1	Funeral		5. Social Security Number 6.	Sex 7.7		last birthday)	If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign
770	Director		213-23-3023	¾ C]M 2□F	24	Yrs.	months Days	110010		03-15-19	81 Sil	ver Spring,MI
9	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
	Manyl	ō	MD Howard		Coli	umbia						1 No 2 No
	with the Maryland to or 28a-1 show	Director	10e. Street and Number		1 001	anora	10f. Zip Code			10	g. Citizen of What C	ountry?
	23a or	DIE	7502 Yellow Bonne	tt Place			21046				US	Δ
	deeth	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U.	.S. 13.	Was Decedent of H	ispanic C	Origin? (Spe	cify Yes or No-	14. Race - Am	erican Indian,
9	ours after deeth with el', or items 23e or Extending count be		1∑Never Married 2☐ Married	1 □ Yes 2X If Yes, Give] No		1 ☐ Yes 2 █ X No	Specif			Specify: Wh	
5-0036	72 hours after "natural", or its	d by	3 Widowed 4 Divorced	Year or Dates	5:]						
5	"na	Completed	15. Decedent's E (Specify only highest gi	ade completed)		(Give	dent's Usual Occup kind of work done i DO NOT use retired	durina mo	ost of workir	ng 1	6b. Kind of Business	vindustry
2121	withi iene. then	E O	Elementary/Secondary (0-12)	College (1-4o	r 5+)	Stude	nt			н	loward Co.	College
p	filed within I Hygiene. other than	0	17. Father's Name (First, Middle, Las	1)		Deade		18. Mot	ther's Name	(First, Middle, M.		COLLEGE
Maryland	s 1 and 2 should be filed withi f Heelth and Mental Hygiene. Itsm 27 is marked other than other traumatic event, Ihe M	To B	John K. Burch Jr.					Judi	th An	n Fulks		
ary	and ha		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street	and Num	ber or Rura	Route Number,	City or Town, State,	Zip Code)
	and and an and an and an and an and an		John K. Burch / E	'ather				nnet			ia, MD 21	
ore	ges 1 ar t of Hee if Itsm or other		20a. Method of Disposition 1 ☐ Burial 2√☐ Cremation 3 (Removal from Sta	te C	emetery, crei	sition (Name of matory or other plac	1			Oc. Location - City or	
Baltimore,	t. Page rtment c rtent: If		4 Donation 5 Other (Spec	ify)	Che		e Crem.	1	09-20		eltsville	
Bal	permit. Pages Depertment of Important: If It any Injury or once.		21. Signature of Funeral Service Lice	22	Witzke fu 5555 Twin	inera Kno	Home	e of Col d., Colu	umbia, IN mbia, MD	C. 21044		
П			23a. Perin. Enter the disease incomplications that caused the death. Do not enter the mode of dying, shock, or heartfailure. A is solven cause on each line.						as cardiac o	r respiratory arres	st,	Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition				ication					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	as a conseq	uence of):						
	- Administr	_	Sequentially list conditions,	b. Dan to for	as a consuc	usmos sille				V-1		
	ted nsit	niner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury		as a conseq	dence on						
	be executed icien and burial-transit	Examin	that initiated events resulting in death) Last	C. Due to (or a	as a conseq	uence of):						
8760,	ate be e hysicien the buria	dical		d								
9	tificate ig phys as the	ledic										
Box	requires that the death certificate een signed by the ettending phys hould be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pregnancy				23d. Date of de	
	the ett	sicie	in the past 12 months?	4☐Pregnant 9☐Unknown	at time of d		Other (specify)				Month	Day Year
P.O.	thet the de ed by the detached	Phy	9 Unknown			. Minn in Mr.				OO- Didash		- the same of death 0
	ires the signed t be de	by	Part II. Other significant conditions	contributing to death	Dut not res	uning in ine u	nderlying cause giv	en in Pan	τι.		_	o the cause of death?
Vital Records,	w requir been si should	Completed		<u>-</u>								
360	a 2 C	E I								24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
a			25. Was case referred to medical				-		-	1 X Yes 2	□ No 1 X Yes	2 □ No
₹	Physician: T this certificet ral director, pa	o Be	examiner? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	Hospital:	tiont 24-1	ER/Outpatier	y all Doa Oth			Check only one	lce 6 ☐Other (Spe	-4.1
ō		n: To	27. Manner of Death	28a. Date of Ir	niury	28b. Time o	28c Injur			8d. Describe hov		unk
Division	분들	ertification:	1 □Natural 5 □ Pending 2 □ Accident investigate	Found:		Found	• M 1 □	k? Yes 2[X No			unk
<u>vis</u>	Attandler death.	ific	3 ☐ Suicide 6 【Could not determined	28e. Place of		ome, farm, str	eet, factory, office		2	8f. Location (Stre City or Town,	et and Number or R	ural Route Number,
Ö	tal or rs afte al Dir ed in	Cer	, , , , , , , , , , , , , , , , , , , ,	T 1		,, sidenc	e				lumbia, Ma	Yellow Bonnet aryland
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edicai	29a. Certifier 1 Certifying P	hysician: To the be miner: On the basis and manner	of examina	wledge, deat tion and/or in	h occurred at the tin vestigation, in my o	ne, date a pinion, de	and place, a eath occurre	nd due to the cau od at the time, dat	use(s) and manner as e and place, and due	s stated. e to the cause(s)
	To th Within To th	Me	29b. Signature and title of certifier				29c. Licens	e numbei	r	296	d. Date signed (Moni	h, Day, Year)
			· Talier	69 Al	ı ^		OCME			S	eptember 1	11, 2005
			30. Name and address of person who	completed cause o	f death (Item	n 23a) (Type,		n C+	wo o t	Do1+	mo M1	and 21201
	Sta	te	31. Date filed (Month, Day, Year)	32 Regis	strar's Signa	iture	III Pen	11 50	reet,	DATUMO	re, Maryla	HIG ZIZOI
	Regist		31. Date filed (Month, Day, Year) SEP 1 5 20	05	לא עם	iture	ule					
DI	MH 17 Pay 1/2	004		4		1			***			

ORIGINAL

		1	For State Registrar	State of Maryland / Depa	artment of Health and I rtificate of Death	Mental Hygie	
	Physici	an	1. Decedent's Name (First, Middle, Last) GRACE	C	RABBE	2. Date of Death Month SEPTEMBE	Day Year 6123 PM
	/Medic Examin	er		PETAL CENTER	4b. City, Town, or Location of Death BALTIMOS If Under 1 Year II Under 24 Hrs.	8. Date of Birth	4c. County ol Death 9. Birthplace (State or Foreign
Aug.	Funeral Director			M 2XF 79 Yrs.	Months Days Hours Min.	11/28/19	ear) Country)
	Maryland -f show		10a. State 10b. County	nne Arundel Gle	en Burnie		10d. Inside City Limits 1 ☐ Yes 2 XXo
	with the	al Director	10e. Street and Number 237 Hammarlee Ro	ad	10f. Zip Code 21060	10g	Citizen of What Country? USA
36	s after deetl , or items 2	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced	Armed Forces? 1 □ Yes 2 🕅 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 Yes 2 Who Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
215-00	within 72 hours after deeth with the Maryland one. than "natural", or items 23a or 28e-f show the Madical Exertine must be collified at	Completed t	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation 16a. Dece	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king 16	b. Kind of Business/Industry
Maryland 21215-0036	perrit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or items 23a or 28e-f show any injury or other traumatic event, the Madical Examinat must be publised at once.	To Be Con	6 17. Father's Name (First, Middle, Last) Millard Hanks	0		ne (First, Middle, Ma 7 Lackham	Own Home iden Sumame)
Mary	nd 2 shoul Ith and Me 27 is mari	F	19a. Informant's Name/Relationship (Ty) Grace Aten / Daug		ng Address (Street and Number or Ru Hammarlee Road, (ural Route Number, C Glen Burni	City or Town, State, Zip Code) e, MD 21060
Baltimore,	Pages 1 ar		20a. Method of Disposition 1XXBurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		osition (Name of matory or other place) ren Cemetery 09/1		c. Location - City or Town, State Len Burnie, MD
Balti	permit. Deportmine Imports any inju		2 Signature of Prograf Service License	or P. Doda, Jr.	Name and Address of Facility Charles L. Stevens 501 East Fort Ave	s Funeral enue, Balt	Home, Inc. imore MD 21230
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	c a septic	- SHOC	Onset and Death
8760,	death certificate be executed as attending physician and ad for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	ACIDOSIS & EVATION MYO MIA		
P.O. Box 68	death certifi e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🗷 No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	Se 00	þ	Part II. Other significant conditions con	ntributing to death but not resulting in the u			cco use contribute to the cause of death? 2 No 3 RProbably 4 Unknown
of Vital Records,	The law te has bage 2 s	Completed				24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No
Vita	ician: sertific ector.	Be	25. Was case referred to medical examiner?	lospital:	Other	ath (Check only one)	
ion of	B e	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	nt 3 DOA 4 Nuising P	28d. Describe how	ce 6 □Other (Specify) rinjury occurred
Division	el or Attendir s after death. el Director: Al	Certification:	3 Surcide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, lactory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	To the Hospitel or Atta within 24 hours after de To the Funerel Directo completely filled in by th	edical		sician: To the best ol my knowledge, dea ner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occ	urred at the time, dat	e and place, and due to the cause(s)
	To the P within 2-	W	29b. Signalure and title of certifier Hirut Gebre	weil (M.2)	29c. License number		d. Date signed (Month, Day, Year) PTEMBER 10, 2005
,	57			ompleted cause of death (Item 23a) (Type	, Print)		Altimore mo. 212
	St	ate rar	31. Date filed (Month, Day, Year) SFP 1 5 26	32. R giŝtrar's Signature	Carle		

		1 - State Registrar 1. Decedent's Name (First, Middle, Last,	State of Marylan	•		f Health a	nd Mental H	Reg. No.	~ ~ ~ ~	30036	
Physic /Med	ical	Alfred Correia 4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			Day 3/27/2	102 50 by		
Exami		Crofton Convalescent Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho			Bowie MD			4c. County of Deeth Prince Georges e of Birth 9. Birthplace (State or Foreign			
Funera Director		035_03_6868 NF3M 2DF 94 Months Days Hours Min. (Month, Day, Year) Country)							Portugal		
e Marylan ia-f show	ctor	D 1							10d. Inside City Limits Yes 2 □ No		
th with the 23s or 28	al Dire	10e. Street and Number 12620 Kavanaugh Lane			10f. Zip Code 20715				. Citizen of What Country? USA		
1215-0036 within 72 hours after death with the Maryland ene than "natural" or Itams 23a or 28a-f show than "natural Examinat to Indillised at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? unk IXXYes 2 □ No If Yes, Give Year or Dates:	. '	Was Decedent If Yes, specify (1 ☐ Yes 🛣	Cuban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Americ Black, White, Specify:		
Maryland 21215-0036 nd 2 should be filed within 72 hours att the and Mental Physiene. 27 is marked other than "natural", or traumatic event, the Modical Exercit	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 0			ecedent's Usual Occupation Sive kind of work done during most of working le. DO NOT use retired) Truck Driver				Transportation		
/land /	To Be C	17. Father's Name (First, Middle, Last) Manuel Correia 18. Mother's Name (First, Middle, Maiden Sumame) Evangelina Lawrence									
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or Itams 23a or 28a-f show eny highry or other traumatic event, the Modical Exemptor in that be notified at ents.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1032 Mt. Airy Rd. Davidson MD 21035									
		20a. Method of Disposition 1									
		21 Signature of Amerial Services are each or P. Doda, Jr. Charles L. Stvens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230									
Pnysician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									
P.O. Box 68760, hat the death certificate be executed to the attending physician and teledached for use as the burial-transit of	ical Examiner										
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	nonths?					2	23d. Date of delivery Month Day Year		
	by						id tobacco use contribute to the cause of death? ☐ Yes 2 ☐ No 3 ☐ Probably 4				
al Record The law requir cate has been si page 2 should I	Completed						auto	a. Was an autopsy performed? I Yes 2 No 1 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No			
Division Hospital or Attanding A hours after death. Funaral Director: After	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)						I Route Number,		
	Medical (29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
To tha within 2 To the complet	Σ	29b. Signature of dittle of certifier 29c. License number 03/136					6	29d. Date signed (Month, Day, Year) AUGU ST 29, 2005 BALTIMURY, MD			
OT			LLACT, MU	,900	Print) 05 K	LBRI	DE H), B	ALT	more	21236	
St Regis	ate trar	31. Date filed (Month, Day, Year) SEP 1 5 2	32. Registrar's Signat	urē <i>K</i>	brant .		,			/	

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	ryland / De	epartment of He Certificate of D	ealth and M Death	lental Hygier Reg. I	^{1e} 2005	30037
5.	1		Decedent's Name (First, Middle, Last)					2. Date of Death	Day Year	3. Time of Death
	Physici /Medic		LAWRENCE E. CARRO	LL, JR.				SEPT. 12	2, 2005	12:30 A.M
	Examin	1000	4a. Facility Name (If not institution, give s GILCHRIST CENTER	treet and number)		4b. City, Town, or I			tc. County of Death BALTIMO	
lošir,	Funeval.		5. Social Security Number 6. Sex	7. Age	(In yrs. last birth		If Under 24 Hrs.	8. Date of Birth	9. Birth	
	Funeral Director		217-12-6407 ¹ X	M 2□F	80 Yr	s. Months Days	Hours Min.	10/19/192	4 MAI	place (State or Foreign Intry) RYLAND
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	or Location				10d. Inside City Limits
	Maryli f eho	ror	MD BALTIMO	⊋F		AVEN VILLAG	F			1 ☐ Yes 2 🕅 No
	r 28e	Irect	10e. Street and Number		DOOM II	10f. Zip Code	<u></u>	10g. (Citizen of What Cou	intry?
	death with the Maryland rins 23e or 28e-f ehow rinust be notified at	a D	8406 GREENWAY ROA	D APT. B		212	34		USA	
9	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. I fleatiful and Mental Hygiene a fleatiful filem 27 is marked other then "naturel," or items 23e or 28e-f ehow other treumatic event, the Medical Examinar must be motified at	by Funeral Director	11. Maritaf Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	2. Was Decedent E Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates:	0	 Was Decedent of His If Yes, specify Cuban Yes 2 Xoo 	panic Origin? (Sp., Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: 1.77	
2	ture!		15. Decedent's Educ	ation	16a. D	ecedent's Usual Occupa	tion	16b.	Kind of Business/I	
	hin 72 9. Media	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) Colfege (1-4or 5-		Give kind of work done du ife. DO NOT use retired)	uring most of work	ina	LTIMORE (· ·
7	e filed within al Hygiene. I other then " vent, the We	Con	8TH GRADE			FIRE FIGHT			IRE DEPT	
	buld be fil Mental H arked otl atic ever	Be	17. Father's Name (First, Middle, Last) LAWRENCE E. CARRO	LL. SR.		-	ABBIE	e (First, Middle, Maid SHOCK	en Sumame)	
2	2 should be and Mental is marked of reumatic ev	2	19a. Informant's Name/Relationship (Typ.		19b. N	Mailing Address (Street ar			y or Town, State, Z	ip Code)
-	and 2 ealth a n 27 is		CHERYL L. RUST/DA	JGHTER	1	REDARE COUR	T PARKV	ILLE, MD	21234	
1D)	es 1 an of Heal of Item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 ② Cremation 3 ☐ Re	moval from State	20b. Place of D cemetery,	hisposition (Name of crematory or other place)	,	Location - City or T	
Daitillio	t. Pag tment tant:		4 □ Donation 5 □ Other (Specify)		METRO C	REMATORY, I			TONSVILL	
00	permit. Pages Department of I Important: If Ite any Injury or of once.		21. Signature of Funeral Service License	θ		22. Name and Address 8521 LOCH				
	1000 T		23 Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused in	the death. Do no				, 1710 2.12	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	LUNG		cer				Onset and Death George
	₽	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	sunsequence of)					
	icate be executed physicien and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of)	p.				
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00	uficate g phy as the	w					7			
	ding Physicien: The law requires that the death certif. At the this certificate has been signed by the attending funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delive Month	very Day Year
cords, r	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions con	nbuting to death bu	t not resulting in th	he underlying cause giver	n in Part I.	1.0		the cause of death?
Ē	:The law recate has be page 2 sho	Completed						24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of 2 No
VIE	Physicien: this certific ral director,	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:		Other		(Check only one)		
	ding Phy n. After this funeral d	tion: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	it 2 ER/Outp / 28b. Tin / Inju	ne of 28c. Injury	4 Livursing no	me 5 Residence 28d. Describe how in		W NOSPICE
DIVISION	or Attenater deat Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	ry - At home, farm (Specify)	n, street, factory, office		28f. Location (Street City or Town, Sta		al Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical C	29a. Certifier (Check only open) Certifying Physical Examination (Check only open)	ician: To the best of er: On the basis of and manner stat	examination and/	death occurred at the time or investigation, in my opi	e, date and place, inion, death occurr	and due to the cause ed at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	lon)	29c. License	8303	29d. [Date signed (Month)	Day, Year) (1) 2005
	54		30. N e and address of person who co	npleted cause of de 3 2.7 trains	ath (Item 23a) (T)	pos Print) les ST	Tonso	s ms 2	1204	Day, Year)
	Sta Registi		SEP 1 5 200	32. 4 tra	r's Signature	frie .			/	

State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** September 7, 2005 Willie Carroll 7:45 PM · /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Annapolis Nursing Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) Funeral Months Hours 1 € M 2 □ F Yrs. Director 239-32-3035 76 June 6, 1929 North Carolina Usual Residence of Deceden death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Washington 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 10 Southeastern Ave SW #212 20032 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 1 No Specify: black. Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) unk Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Annapolis Nursing Center 900 Van Buren Street Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☒Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Licensee Ronald S. Wage, Director Baltimore, MD 21201 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner the attending physician and thed for use es the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown signed by à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 should has 1 ☐ Yes 2 ☐ No 1 Net or Attending Physician: efter death.

Director: After this certifice Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 🗌 No 2 Accident 6 Could not be determined 3 Suicide To the Hospital or Atte within 24 hours effer de To the Funerel Directo completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 4203 Queensbury Rd Hyattsville MD 20781 DEVORE A. PAUL 32. Régistrar's Signature 31. Date filed (Month, Day, Year) State 1 5 2005 Registrar

State of Maryland / Department of Health and Mental Hygieney 30039 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SEPTEMBER 12, 2005 BESSIE COHEN 7:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6411 DORAL DRIVE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. 7. Age (In yrs. last birthday) 8. Date of Birth Month Day Year) MAR. 7, 1911 Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2**Q**F 94 215-40-1685 Yrs. Director RUSSIA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits treumatic event, the Medical Examiner must be putified at Director N/A 1 X Yes 2 □ No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 6411 DORAL DRIVE #D 21209 or Items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: WHITE 3 Widowed 4 Divorced netural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) al Hygiene. College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill Health and Mental H tem 27 Is marked oth Be SIMON SCHWART7 TILLIE KAUFMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Importent: If item 27 Is
eny injury or other treu MARILYN BERMAN / DAUGHTER 7121 PARK HEIGHTS AVE. #904 - BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LUBAWITZ NUSACH ARI (NER 9/14/05 ROSEDALE, MD 21. Signature of Fineral Service Licer 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiovascular Disease atheroscherotic /Medical Examiner Pepha Ulan Disease Sequentially list conditions Completed by Physiclan/Medical Examiner If any leading to in medicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit physician s the burial Box 68760. Depression IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ö in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Immobility 1 Yes 2 No 3 Probably 4 hnknown legally dect and bland 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 1 ☐ Yes 2 No Other: 4 \(\text{Nursing Home} \) Statement Residence 6 \(\text{Other} \) (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

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completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) Thelis 09-13-2005 D23679 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenneth L. Glick 12221-3 LUTHERVILLE MO 21093 M.D. TULLAMORE RD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 5 2005

ORIGINAL

			For Stete Registrar	State of M	aryland / Dep	ertificate of			iene eg. No20(15 3ՈՈՒՈ
	Dhusiai		Decedent's Name (First, Midd	dle, Last)				2. Date of Dea	th	3. Time of Death
	Physicia /Medic		MAX	LE0		COHEN			ER 12, 2	
	Examin	er	4a. Facility Name (If not institution 6411 DORAL DF			4b. City, Town, o	r Location of Death BALTIMO		4c. County of	N/A
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthda)	/) If Under 1 Year	If Under 24 Hrs.		Voorl	9. Birthplace (State or Foreign Country)
	Director		215-22-8379	1 M 2 F	97 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day APR.19,	1908	MD
	and and		Usual Residence of Decedent 10a. State 10b. Count	y	10c. City, Town or I	_ocation				10d. Inside City Limits
	Mary -f sho	tor	MD I	N/A	BAL.	ΓΙΜΟRE				1 X Yes 2 □ No
	or 28e	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	nat Country?
	s 23a	rail	6411 DORAL DI		5	W 5 () (21209		14.0	USA
	ter de Item	une	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	12. Was Decedent Armed Forces irried 1 ☐ Yes 2 [X	No 13	. Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black,	- American Indian, White, etc.
21215-0036	within 72 hours after death with the Maryland ane "neturel", or Items 23a or 28e-f show the Madical Examiner must be notified at	ğ	3 X Widowed 4 □ Divorce	If Yes Give		1 ☐ Yes 2 💢 No	Specify:		Specify:	WHITE
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d 2	be filed within 72 hours after death with the Marylar Ital Hygiene. Id other than "natural", or flems 23a or 28e-f show other than "natural", or flems 23a or 28e-f show event. It a Madical Examinat must be notified at	Be Co	17. Father's Name (First, Middle		11.0	2		ne (First, Middle,		
ylar	should be id Mental marked c metic ev	ToE	ABRAHAM		СОН		ZLATY			DAVIDOWITZ
Maryland	ges 1 and 2 should t of Health and Men If item 27 is marke or other treumetic	8 1	19a. Informant's Name/Relation MARILYN BERM			ling Address (Street				nate, Zip Code) ORE, MD 21215
	s 1 and of Healt item 2 other	1	20a. Method of Disposition		20b. Place of Dis	oosition (Name of ematory or other place				ity or Town, State
D E	Pages nent of nt: If i		1 🕅 Burial 2 □ Cremation 14 □ Donation 5 □ Other (/14/2005	ROS	SEDALE, MD
Baltimore,	permit. Pages 1 Department of t Importent: If ite any injury or ot once.		21. Signature Funeral Service	e Licensee	1	22. Name and Addre	ss of Facility SO	L LEVINS	ON & BRC	OS., INC.
u E	205 g g		23a. Part1. Enter the disease, of	12 Cum						E, MD 21208
			shock, or heart failure. List Immediate Cause (Final	st only one cause on each	ine.		ig, such as cardiac	or respiratory arr	est,	Interval Between Onset and Death
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Вох	leath c attend	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth	2 Fetal death 3	☐ Ectopic pregnancy	/		23d. Date Monti	
P.O.	by the detached	hysi	9 Unknown	9□ Unknown						
	res tha	by	Part II. Other significant conditions Spinal Science		out not resulting in the	underlying cause giv	en in Part I.			ute to the cause of death?
Records,	w require been si	ompieted	Spinal of	10103 12						Probably 4 Munknown
Rec	The taw ate has I page 2 s	mpi						24a. Was a autops perform	ned? pri	ere autopsy findings available or to completion of cause of ath?
Vital		e C	25. Was case referred to medic	al			26. Place of Dea	1 ☐ Yes : th (Check only on		Yes 2 No
of V	d 55	To B	examiner? 1 ☐ Yes 2 KNo	Hospital: 1 Inpat	ent 2 ER/Outpati	ent 3 DOA Oth	er: 4 Nursing H	ome 5 Reside	ence 6 Other	(Specify)
		lon:	27. Manner of Death 1 ★Natural 5 □ Pend		ury 28b. Time ay Year) Injury	Wor	k?	28d. Describe ho	ow injury occurred	
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Ω	s after al Dire	Certification:	4 Homicide deter	building, e	tc. (Specify)			City or Town	1, State)	
	To the Hospital or I within 24 hours after To the Funeral Directorpletely filled in b	edical	29a. Certifier 1 certify (Check only one) 1 Medice	ing Physicien: To the bes of Exeminer: On the basis and manner s	of examination and/or	ath occurred at the tir investigation, in my o	пе, date and place, pinion, death occui	and due to the carred at the time, d	ause(s) and manr ate and place, an	ner as stated. d due to the cause(s)
	To t To t	Σ	29b. Signature and title of certif	1 1.1 11.15		29c. Licens	1/00		44	(Month, Day, Year)
	10		30. Name and address of person Kennem L 31. Date filed (Month, Day, Year SEP)	n who completed cause of Glick n	death (Item 23a) (Type	e, Print)	TULLAMOR	rero. L	4THERVIL	LC MD 21093
	Sta Registi	ite rar	31. Date filed (Month, Day, Yea	1 5 2005 32. Refs	rar's Signature	porte				

			1 - For Registrar	State of M	laryland /		artment				lental Hyg	giene eq. No. 200	5 3004
		1)	Decedent's Name (First, Middle, Last)								2. Date of Dea	th	3. Time of Death
	Physici /Medic		Helen Virg	nia Ca	11oway						Month Septeml	Day Yea Der 12, 20	05 8:05A M
	Examin		4a. Facility Name (If not institution, give str				4b. City,	Town, or	Location of	of Death		4c. County of De	
			24707 Ridge Road					ascu				Montgo	mery
	Funeral		5. Social Security Number 6. Sex	7. A	ge (In yrs. last i 80	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day		irthplace (State or Foreign Country)
	Director		Usual Residence of Decedent			113.					April 2	25, 1925	Maryland
	yland		10a. State 10b. County		10c. City, To	own or Lo	cation					·	10d. Inside City Limits
	Man 3-f st	tor	Maryland Montgomer	у	Rock	vill	e						1√2 Yes 2 □ No
	or 28	ire	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of What	Country?
	23e ust b	rai	310 Lawrence Avenu	e				208	50			U.S.A.	
	ar de:	Funeral Director		. Was Deceden Armed Forces	?	13.	Was Deced f Yes, spec	ent of His	spanic Ori	gin? (Spe i, Puerto l	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi	nencan Indian, nite, etc.
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 🗶 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give X Year or Dates:] No		1 ☐ Yes 2	X No	Specify:			Specify: Wh	ito
Ş	filed within 72 hours after death with the Maryland Hygiene. other then "neturel", or Items 23e or 28e-1 show ent, the Madical Examinar must be notified at	edt	15. Decedent's Educa			a. Deced	dent's Usua	I Occupa	tion			16b. Kind of Busines	
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g	al Hygid other vent, L	Be (17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle, I	Maiden Sumame)	
Na Na	should be and Mental marked o umetic eve	10	William McKinle	y Jenk						the			
Maryland 21215-0036	2 short and ls m	1,)	19a. Informant's Name/Relationship (Type	•								City or Town, State	
e oî	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or items 23e or 28e-1 show any injury or other treumetic event, the Madical Examinar must be notified at 000s.		Janet Guynn - Daugh	ter		are and			oad,			Maryland	20872
altimore,	Pages 1 nent of H ont: If ite		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Rer	noval from State		tery, cren	natory or ot	her place		ں /15/		20c. Location - City of	r Town, State le, Maryland
<u>=</u>	permit. Pag Department Importent: I any injury o		'4 Donalton 5 Other (Specify)		St. P								
Ba	permi Depa Impo any is		21. Sign ture of Funeral Service Licensee	00:)	oΊ	in L.	Mo I	eswo1	th E	P.A., Fu	neral Hom	e
			23a. Part1. Enter the disease, or complica	tions that cause	ed the death. D	26	401 R	idge	Road	l, Da	mascus,	Maryland	20872 Approximate
			shock, or heart failure. List only one Immediate Cause (Final	cause on each	line.			4			r rospilatory arr	551,	Interval Between Onset and Death
	Priysician /Medical		disease or condition resulting in death)	-	ESPI P		KY 1	CATIC	LUKE	-			
	Examiner			Due to (01 a:	MNG	e or):	WICE	2					
7		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a:	a consequenc	e of).	100						
V	cuted nd ransit	Examiner	that initiated events										
o,	exerian ar	Ex	resulting in death) Last	Due to (or as	s a consequenc	e of):							
8760	cate be executed oblysician and the burial-transit	dicai	d.										
<u> </u>	ertific ling p e as l	Mec	IF FEMALE:										
ROX	death certific e attending pl id for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal dea		Ectopic pre					23d. Date of d	elivery Day Year
o	0 0	ysic	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4∐Pregnant a 9☐Unknown	at time of death	5∟	Other (spe	ecify)					24, 700.
'n	g 20 g	/ Ph	Part II. Other significant conditions contri	buting to death I	but not resulting	in the ur	derlying ca	use giver	n in Part I.		23e. Did tob	acco use contribute	to the cause of death?
Vital Hecords,	w requires to been signed should be	d by					, ,				1 ☐ Ye	s 2 □ No 3 4□ F	Probably 4 Unknown
င်္ဂ	w req	lete									24a. Was a	24h Were s	autopsy findings available
Ä	The lav	Completed									autops: perforn	y prior to ned? death?	completion of cause of
g		0	25. Was case referred to medical						26 Place	of Donth	1 ☐ Yes 2	No 1 ☐ Ye	s 2 No
	Physicien: r this certifica ral director, p	To B	examiner?	pital:	ent 2 ER/C	Outpatien	3 DO	Other			-	nce 6 🛣 Other (Sp	Daughters
ס ר	ding Ph h. After thi funeral		27. Manner of Death	28a. Date of Inju	ury 28b	. Time of		c. Injury : Work?				w injury occurred	Residence
Ö	Mtendin death. ctor: Af y the fur	atic	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(147071177, 251	2) / 54./	injury	М		es 2 🗆 N	No /			
DIVISION	l or Attendater deatl Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	jury - At home, tc. (Specify)	farm, stre	et, factory,	office		2	8f. Location (Sti	reet and Number or F , State)	Rural Route Number.
	pitel or ours after terel Dir filled in									1			
	Hos 4 h Fun	edical	29a. Certifier 1 ☑ Certifying Physic (Check only one) 2 ☐ Medical Examine	: On the basis of	of examination a	ge, death and/or inv	occurred a estigation,	it the time in my opi	, date and nion, deat	t place, a	nd due to the ca	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
	To the Hos within 24 hr	Med	29b. Signature and title of certifier	and manner st	tated.			License					
	T w S	-	Signature and into or continuous			11	7	7001130	3 4-	DC	ē) "	Od. Date signed (Mon	Y / 250.5
			20 Name and address of several inter-	2N	doub //		2	100	~J~	2		0111	1 000
	15		30. Name and address of person who com					۸		0-2-	11		1 00077
	Sta	te	Karowiec, M. 31. Date filed (Month, Day, Year)	32. Re	NOTTH ar's Signature	rred	erick	Avei	nue,	Gait	nersbur	g, Marylar	nd 20877
	Registr		SEP 1 5 200	5	eva b	. 6	porte	,					

Reg. No.

Physician /Medical Examiner	

The law requires that the death cartificate be axecuted attanding physician and for usa as tha burial-transit Division of Vital Records, P.O. Box 68760, signad by tha a cartificata has baan si iractor, paga 2 should this Aftar this funaral d

Baltimore, Maryland 21215-0036

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 2124 Month J. Dawson ectembia 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Center NICOMICO Regional Medicu Peninsula Salisbury If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Nov . 21 9. Birthplace (State or Foreign Country) West Virginia **Funeral** Days Hours 216-28-7339 1**∑**M 2□ F 72 **Director** Usual Residence of Decedent fitad within 72 hours aftar daath with tha Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural, or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Md. Worcester Co. Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5101 Costal Highway #26 21842 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A 8 Operating Engineer Construction Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) parmit. Pagas 1 and 2 should be fift Dapartment of Health and Mantal Hy Important: if Item 27 is marked oth any injury or othar traumatic event 2008. Be R. A₁v_y Dawson Velva Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Christine Kocher (Former Wife) 7677 Bush Ave. Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 9/12/05 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee McCully-Folyniak Funeral Home, P.A. ha Willias 237 Last Patapsco Ave, Baltimore, Maryland 21225 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RESPONDING DISTUSS a ADULT disease or condition resulting in death) SMORGHE 1 WEEK /Medical Due to (or as a consequence Examiner b. Due to (or as consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 205645 Examiner Due to (or as a consequence of): YENES resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check ont one) 29b. Signature and title q certifie 29c. License number 29d. Date signed (Month, Day, Year) D53551 9-9-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 lodd Piwe Bluff Rd Salisbury, Md. 21801 James 201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

SEP 1 5 2005

			1 ⊷ For State Registrar	State of Ma			of Health of Death)	Reg	2005	3004	3
	Physici /Medic		1. Decedent's Name (First, Middle, La Rita Marie Dougl						2. Date of Death Month eptembe:	r 14 200	3. Time of Deat	th M
	Examir	ner	4a. Facility Name (If not institution, giv 8518 Wind Dance V			Col	own, or Location umbia	of Death		4c. County of De Howard	ath	
	Funeral Director		215 14 6889	7. Age	(In yrs. last birthd	Months	Year If Under Days Hours	Min. 2	B. Date of Birth 2/14/191	8 Mai	irthplace (State or For Country) Cyland	eign
	-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County MD HOWA:	rd	10c. City, Town or						10d. Inside City Lin	
3	with the	Director	10e. Street and Number 5366 Flight Feat			10f. Zip C			}	D. Citizen of What (Country?	
36	z should be filed within 72 hours affer death with the Maryland and Menth Hygiene. Ie marked other then "naturel", or itema 23e or 28e-1 ehow aumatic event, the Marilcal Examiner material per notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Ses 25 N If Yes, Give		3. Was Decede	nt of Hispanic Or y Cuban, Mexica	in, Puerto Ri	fy Yes or No-	14. Race - An Black, Wh	nencan Indian, nite, etc.	
Maryland 21215-003	vitnin 72 nour ne. hen "naturel Madical E.	Completed t	15. Decedent's E. (Specify only highest gra		+) (G	o. DO NOT use	done during mos retired)	st of working		b. Kind of Busines	s/industry	
land 2	œ = ° >	To Be Co	8 17. Father's Name (First, Middle, Last, Fred Steinfelt		Se	cretary	18. Moth		First, Middle, Ma censhrub		raing	
	and z should ealth and Men n 27 le marke er traumatic		19a. Informant's Name/Relationship (Jacqueline Conarto		19b. M	illing Address (\$366 Fli	Street and Numb	er or Rural F ther	Route Number, C	City or Town, State,	Zip Code) L045	
Ψ,	Pages 1 ar		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif			rematory or oth	er place)	Dat		c. Location - City of		
Baltii	permit. Yages 1 and 2 should by Depertment of Health and Ments Important: If item 27 ie marked eny injury or other traumatic e <u>once</u> .		21. Signature of Funeral Service Licer			22. Name and	Address of Facili	^{ity} Harr	y H. Wi	rkville, tzke's Fa ott City.	MD amily FH Ir MD 21043	nc.
E	Chysician be executed a attending physician and was as the parial-transit of or use as the burial-transit.	dical Examiner	23a. Parti. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a Due to (or a)	etes Maconsequence of): ERTENA a consequence of):	elliti	LS	cardiac of r	ospiratory arrest		Approximate Interval Between Onset and Death	
O. Box 6	trine death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	2 Fetal death	B □Ectopic preg	nancy ify)		•	23d. Date of do Month	elivery Day Year	
rds, P.	ins law requires that ste has been signed by page 2 should be deta	۾	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the	underlying cau	se given in Part I	l.	23e. Did tobac	2.	to the cause of death?	
		Completed							24a. Was an autopsy performe	prior to	utopsy findings availal completion of cause of	ble of
r Vital	is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2♥ No	Hospital: 1 ☐ Inpatier	nt 2 🗆 ER/Outpat	ent 3 DOA	Other		Check only one) 5 □ Residence	e 6 💆 Other (Sp.	Asst. L	<i>1</i> g.
Division of	or Attending Proyecten: iffer death. Director: After this certific in by the funeral director.	Certification: 7	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not bi			M	Injury at Work?	No 280	d. Describe how	injury occurred		
Div	urs after death oral Director: ,		4 Homicide determined	building, etc.					City or Town, S	State)	Rural Route Number,	
2	within 24 hours a To the Funeral C	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Examone)	ysician: To the best o niner: On the basis of and manner stat	examination and/or	ath occurred at investigation, in	the time, date an my opinion, dea	nd place, and ith occurred	d due to the caus at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)	
}	Tot	Σ	29b. Signature and little of certifier) ·			100 100 Number 100 100 100 100 100 100 100 100 100 10	.5	29d.	Date signed (Mon	th, Day, Year)	
	2		30. Name and address of person who 5450 Knoll I)・ completed cause of de といなか フィ・	ath (Item 23a) (Typ	e, Print)	dombra	MD	21045	- Willia	7m SAWAY 1	W)
	Sta Registr		31. Date filed (Month, Day, Year)	32. Redistra		A						

State of Maryland / Department of Health and Mental Hygien 2005 30045 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death September Day **Physician** -05 PM 11,2005 Anna Mae Drab /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Center Baltimore Washington Medical Burnie Anne Arundel If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 🗓 F Director 218-18-9855 89 PA Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location Item 27 ie marked other than "naturel", or Itama 23a or 28a-f ehow other traumatic event, the Medical Examinat must be rotified at 10d. Inside City Limits Director 1 ☐ Yes 2 TNo Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 303 Fernglen Ave. 21061 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglens Important: If Item 27 Ie marked other tha any Injury or other traumatic event, The Apres. Homemaker Home Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Peter Stapinsky Clara Stapinsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Fernglen Ave, Glen Burnie, MD 21061 Mr. John Drab, Sr. / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State > □ Depation 5 □ Other (Specify) Glen Haven Mem. Park | 9-14-2005 Glen Burnie, MD 21. Signature of Funeral Service Lic 22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW, Glen Burnie, MD 23a. Part Inter the disease, — complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SERSK **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ENAL INSUFFICIENCY. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed HYPOMATREMIA Que to (or as a consequence of) Division of Vital Records, P.O. Box 68760. EMENTIA Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) the a signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 s 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 No 1 Ves or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 Yes 2 No rthis Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide To the Hospital within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and file of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1) 4514 MY> SEPTEMBER-11-2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Burrie ONABO 301 MI) 21061 Herpital armore 0 31. Date filed (Month, Day Year) 32. Registrar's Signature State Registrar

Amend item#11,15,17,20a-c,22, per FH, G847, 9/15/05 TI State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.2 0 0 5 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** 2005 September 1, Hntoine the /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Dec 22, 19 Birthplace (State or Foreign Country)
 unk 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months **Funeral** 1□ M 2ਊ F Yrs. 1964 40 Director 216-88-7446 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a State 10b. County item 27 is marked other then "naturel", or Items 23s or 28s-f show other treumatic event, the Madical Examinar must be notified at 1 X Yes 2 □ No Baltimore MD Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21214 IISA 218 N. Kenwood Avenue e filed within 72 hours after death and Hygiene. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? unk ☐Yes 2MNo Yes, Give 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: black If Yes, Give Year or Dates: by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) disabled 10th unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent: If Item 27 Is marked oth any injury or other treumatic event 2016. Be Melvin Brooks Beverly Forrest 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 218 N. Kenwood Avenue Baltimore, MD 21214 Luana Clark/caregiver 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ Removal from State '4 □Donation 5 MOther (Specify) in State 9/15/05 Baltimore, MD **Bayview Crematory** 22. Name and Address of Facility Beverly D. Cronartie Funeral House State Anatomy Board 655 W. Baltimore Street 21. Signatur Funeral Service Licensee Ronal S. Warde Director

S. Warde Director

22. Name and Address of Facility Beverly, D. C. State Anatomy Board 655 W. Baltimore, MD 21201 5943 Charshoot or heart failure. List only one cause on each line. 21201 5943 Charles St. Balto, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac Arrest **Physician** /Medical **Examiner** End stage Re. Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ed by the attending physician and detached for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed Disseminated cryptococcal infection 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2. No Stroke 1 ☐ Yes 2 ☐ No 1 ☐ Yes the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No this After this funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29d. Date signed (Month, Day, Year) 29c. License number 10 D0053352 MD 9/6/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 725 W. Lombard St., Baltimore, mD 21201 Charles E. Davis, Tr MD 31. Date filed (Month, Day, Year) SEP 1 5 2005 32. Registrar's Signature State Steller

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 30047 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 13, 2005 Year 6:25 P M Fischetti 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Care Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth May 16, 1942 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 2 1 F 63 Yrs 149-32-5382 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2X No Gloucester 4 Williamstown New Jersey 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 08094 USA 2421 Sunset Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) 12th Head Clerk Hote1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Davis William Brining 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 320 Sunray Court Abingdon Maryland 21009 Dana Gordon /Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 9/19/05 R.A. Ferris & Co. West Chester PA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Christina L. Hilton feonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cancer UNG rears Due to (or as a consequence of) Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify)

Physician /Medical Examiner

Department of Important: if eny injury or gages.

Physician

/Medical

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Completed by Funeral

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Funeral

Director

27 is marked other then "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar maintible notified at

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Maryland 21215-0036

Baltimore,

Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Physician/Medical ģ Completed After this certific funeral director, Be ٩ Certification: il Director: A within 24 hours after or To the Funeral Direct completely filled in by Medical

Division of Vital Records, P.O. Box 68760.

9 ☐ Unknown (3CI OTRITOWIT				
and II. Other significant conditions of CUMPIC OBJA				1	se contribute to the cause of death? No 3 Probably 4 Unknown
	V			24a. Was an autopsy performed? 1 ☐ Yes 2 ② No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
5. Was case referred to medical			26. Place of D	eath (Check only one)	
examiner? 1 □ Yes 2 Ž No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence 6	Other (Specify)
7. Manner of D ath 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred
3 ☐ Suicide 6 ☐ Could not be determined		nome, farm, street, factify)	tory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,)
	nysician: To the best of my kn miner: On the basis of examin and manner stated.				and manner as stated. place, and due to the cause(s)

58303

29d. Date signed (Month, Day, Year)

September 14 2005

State Registrar

31. Date filed (Month, Day, Year)

29b. Signal

30. Name and address of person who completed cause of death (flem 23a) (7/190, Print)

AANIN CHALLES M CACOI N. CHARLES ST TOWSON MD 21204

To the

	•	For State Registrar	State	of Mary	land / De <i>C</i>	partmer e <i>rtifica</i> :				ental Hy	giene Reg. No		0.5	00010
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Examin Funeral	er	4a. Facility Name (If not institution St Thomas Moore) 5. Social Security Number		7. Age (In	yrs. last birthda	Нуа	ttsvi r 1 Year	llle	24 Hrs. Min.	8. Date of Bi	rth ay, Year)	9. Birthpl	ace (State or Foreign
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4		30. Name and address of person	VORE.	mb 4:	2030	oe, Print)	usbu	my R	d t	lyatt	50.7	led	u):	2005
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3		Usual Residence of Decedent 10a. State 10b. Count	у	10c. City,	, Town or Lo						1	10d. Inside City
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State of Maryland / Department of Health and Mental Hygiene 2005 30050 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** DOROTHY ROBINSON 11:30 A.M GREER SEPTEMBER 11, 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FOREST HILL HEALTH FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 ST 98 Yrs. 3, 1906 Mary Land Director 215-28-9414 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Heath and Menta Hygiene.
ant: If item 27 is marked othar than "natural; or items 23a or 28a-1 show ary or other traumatic avant, I'm Maryled Examitment and be multilied at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 No Bel Air Director Maryland Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 605 Lee Way 21014 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Sara (UNK) Bell Clayton (UNK) Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sara K. Parker/Daughter 21014 605 Lee Way, Bel Air, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) permit. Page Department o Important: If any injury or once. 9-15-05 Bel Air Mem. Gardens Bel Air, MD Service Licenses 22. Name and Address of Facility
McComas Funeral Home, P.A. ra of Funaral McComas Funeral Home, P.A.
50 W. Broadway Street, Bel
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Air, MD 21014 Approximate Interval Between Onset and Death mmediate Cause Final Physician disease or condition resulting in death) /Medical Tue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the a P.0. 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 21-No 2 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide n 24 hou... the Funaral Dirr Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 the th 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Dund SD 5032225 SIPT 12 7405 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID DUNN 615 W. MACPHAIL ROAD BEL AIR, MD. 21014 31. Date filed (Month, Day, Year) State SEP 1 5 2005 Registrar Marie H. Joseph

DHMH 17 Rev 1/200

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra 30051 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 12, 2005 **Physician** MARY HOWARD C. 7:35 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST CENTER FOR HOSPICE CARE TOWSON BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 1 ☐ M 2 🛣 F Months Days Hours Min Director 10-12-1943 218-44-8620 61 MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No BALTIMORE MILFORD Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or itams 23a or 7928 DUNHILL VILLAGE CIRCLE 21244 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2KMarried 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Specify: Year or Dates: BLACK natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hyglene. 7 is marked other than "r Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) 12 FACTORY WORKER LUCENT TECHNOLOGIES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be OLION CRAIG ALLIE FOWLKES ဂ္ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health ar JIMMIE HOWARD/ HUSBAND 7928 DUNHILL VILLAGE CIRCLE BALTIMORE, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: if itel
eny injury or ott 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) METRO CREMATORY 9-14-2005 BALTIMORE, MARYLAND 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licenses 1701-31 LAURENS ST. BALTIMORE, MARYLAND 21217 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc, or heart failure. List only one cause on each line. ames Approximate Interval Between Onset and Death Immediate Cause (Final Brust Cancer Physician disease or condition resulting in death) Rars /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Dillo
9 Unknown Month Day 4 Pregnant at time of death Year 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 4 Unknown Completed 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence Mother (Specifylospice Hospital: Certification; To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending death. 1 Yes 2 No Director: / 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours after To the Funeral Dire Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, feath convited at the time, date and place, and dee to the causa(s) and manner as stated Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 58303 September 13 2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aproncharle as 6601 N Charles ST HUNSON has ZILOY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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DHMH 17 Rev 1/2001

Registrar

2005

State of Maryland / Department of Health and Mental Hygiene 2005 For State Registra 30052 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day 2005 **Physician** 6:00 P M SEPT. 13, LULA LILLIAN HOFFMAN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner GENESIS ELDERCARE HAMMONDS LANE ANNE ARUNDEL BROOKLYN PARK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year, AUG. 22, 1903 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5 Social Security Number 6 Sax **Funeral** Days Hours MARYLAND 1□M 2፟MF 102 212-03-4456 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Insportant: If item 27 is marked other than "natural, or items 23a or 28a-f show any njury or other traumatic evant, Ite Medical Examinating and Language. 1 ☐ Yes 2 ▼ No MILLERSVILLE Directo MARYLAND ANNE ARUNDEL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 339 REDWOOD GROVE COURT 21108 UNITED STATES Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: 3XXWidowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CARRIE SANDS VALENTINE TYLER 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 339 REDWOOD GROVE CT. MILLERSVILLE, MD 21108 ROBERT P. HOFFMAN / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition SEPT_16, 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) GLEN BURNIE, MARYLAND GLEN HAVEN MEM. PK. 22. Name and Address of Facility
KIRKLEY-RUDDICK FUNERAL HOME P.A.
421 CRAIN HWY. S.E. GLEN BURNIE, MD lure of Fune all Service Licensee Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIOURSENIAR MAGNIOSCI Physician FREDT W /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner g physician and as the burial-transit certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ DISMENTIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 🙀 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 X No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After tl Certification: Injury 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier SEPTEMBER 14, 2005 021776 My 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANDVER ST SACTIMORE 21225 MUNDRA MO 30015. 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State 5 2005 SEP 1 Registrar

State of Maryland / Department of Health and Mental Hygiene 200530053 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 10:20 P Regina Ann Herring Sept. 12 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner 18733 Spooks Hill Rd. Parkton Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 □ F Yrs 218-70-9349 48 Nov. 12 1956 MD Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r then "natural", or items 23a or 28a-f show 1 ☐ Yes 2 XNo Director Baltimore Parkton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 18733 Spooks Hill Rd. 21120 death v Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Purchasing Agent 12 n/a Chemical other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any injury or other traumatic event, QDEB. 17. Father's Name (First, Middle, Last) Be Raymond McDermott Bernice Dowdy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) George A. Herring/husband 18733 Spooks Hill Rd., Parkton, MD 21120 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 21093 21 Signature Superal Scaving Licenses ^{22. Name and} Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Bryan W. Inc. Clary Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the shock, or heart failule. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): two months Physician /Medical Examiner Acute myeloid leukemia one year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Division of Vital Records, P.O. Box 68760,-Due to (or as a consequence of): attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No
9 Unknown 4□Pregnant at time of death 5 Other (specify) detached the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ eq 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed 2 No 1 Yes certificate 1 TYes Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 29c. License number 130052391 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1650 Orleans St. Room 243, Balto., MD Mark Levis, M.D31. Date filed (Month, Day, Year) SEP 1 5 2005 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

SEP	H HERMA	IN .	For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of F			giene ,	2005	30054
	Physici	an	1. Decedent's Name (First, Middle, Las	n He rma n				2. Date of Dea Month	ath Day	Yeer	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give 2700 BROENING HIG	street and number)		4b. City, Town, o	r Location of Death ORE CITY	SEPT.		2005 ounty of Death	0410 A ^M
	Funeral Director		Social Security Number 6. S	ex 7. Age	(In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Dec • 5,	y, Year)	9. Birthi Cou N. Y	place (State or Foreign ntry)
	faryland lehow	or	Usual Residence of Decedent 10a. State 10b. County CA Oran		10c. City, Town or Lo Mission						10d. Inside City Limits 1 ☐ Yes 2√2 No
	with the N 3e or 28a-	Funeral Director	10e. Street and Number 27734 Via Saras	ate		10f. Zip Code 9269	2		10g. Citizer	n of What Cou	ntry?
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Maryland 2	permit. Pages 1 and 2 should be filed within Depertment of Heelih and Mental Hygiene. Important: If item 27 ie marked other than any Injury or other traumatic event. The Means once.	To Be Co	17. Father's Name (First, Middle, Last) William Oscar	Herman			18. Mother's Nam Beatric	e (First, Middle, ce C. Me		ımame)	
	and 2 shouselth and No. 27 le mai		19a. Informant's Name/Relationship (19a Betty Ann Herman		2773	ng Address <i>(Street</i> 34 Via Sa	rasate Mi	ssion V	iejo,	CA 926	92
Baltimore,	. Pages 1 tment of He tant: If iter jury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	·)	Bayview (matory or other place Crematory	200	.13, 05		tion - City or To imore]	
Ball	permit. Pa Depertmen Important: any Injury once.		21. Signature of Funeral Service Licer	\$ 00	2:	2. Name and Addre Charles L. 1501 Fast	ss of Facility Stevens F Fort Ave B	uneral Ho altimore 1	me Inc. MD 2123	3 0	
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	Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	consequence of):						
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	w requires that been signed b should be dete		Part II. Other significant conditions of	ontributing to death bu	t not resulting in the u	inderlying cause giv	en in Part I.		obacco use /es 2 🗆 h		he cause of death? Dably 4 Unknown
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Vita	Physician: The this certificete har director, page	o Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatie	nt 3□ DOA Oth	26. Place of Dea	th <i>Check only o</i>		You /0	AT SCENE
Division of Vital	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		of 28c. Injur		28d. Describe h			y) AI DOMAIN
Divis	al or Atters after design Director	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	ry - At home, farm, st . (Specify)	reet, factory, office		28f. Location (5 City or Tox		Number or Run	al Route Number,
	he Hospit in 24 hour. he Funera bietely fille	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Madical Exam	ysician: To the best of ninar: On the basis of and manner stat	examination and/or in	th occurred at the tire	ne, date and place, pinion, death occur	and due to the cred at the time,	cause(s) an date and pla	nd manner as s ace, and due t	stated. o the cause(s)
	To the To the comp	Ž		a AR			.C.M.E		SEP	igned (Month, Γ . 11 ,	
	121		30. Name and address of person who ZABIUCCA	-		STREET,	BALTIMORE	, MARYLA	ND 212	201	
	Sta Regist		31. Date filed (Month, Day, Year) SEP 1 5 2	32. Registra	r's Signature	parte		¥			

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- 4	Physici /Medi		1. Decedent's Name (First, Middle, L ISAAC JC	INES				2. Date of De Month	Day Year	3. Time of Death
*1	Examir - Funeral	er	5. Social Security Number 6.	Ve street and number) TYLAND MEDICAL Sex 7. Age (In yrs. I	CENTER last birthday)	BAL If Under 1 Year Months Days	Location of Death If Under 24 Hrs. Hours Min.	8. Date of Bir	4c. County of Death W th av, Year 9. Birth	nplace (State or Foreign
***	Director		Usual Residence of Decedent 10a. State 10b. County	17/	Yrs. Town or Local		-	Nov. 2	1957M7	10d. Inside City Limits
	death with the Maryland ms 23s or 28s-f show rither to multiple at	i Director	10e. Street and Number	A 15)Atti	more 10f. Zip Code			10g. Citizen of What Co	1 □ Yes 2 □ No untry?
920	or Ita	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		is Decedent of His es, specify Cuban Yes 2 No	panic Origin? (Sp., Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race - Amer Black, White Specify: B	
21215-0036	I within 72 hours iene. r then "naturel',	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)		(Give kin	NOT use retired)	tion uring most of work	ing	16b. Kind of Business/I Sel-P-Er	2 .
Maryland 2	thould be filed within and Mental Hygiene. marked other then marked other then marked other then matic event, the Mental transfer and transfer and the Mental transfer and	To Be C	17. Father's Name (First, Middle, Las 15 A A C 19a. informant's Name/Relationship	bris Sk	2-	J	ROSE,	LEE	Major Sumame)	vn
	les 1 and 2 s of Health ar of Item 27 le		BRENDA J. 20a. Method of Disposition 1 Burial 2 Cremation 3 [0 n ES 206. P	63/ lace of Dispositi	EAST.	30 5	Date	er, City or Town, State, Z	11.21218
Baltimore	permit. Pag Department Important: any injury c		4 □Donation 5 □Other (Special Signature of Funeral Service Liet	(ty) / 15 (ng Me	ame and Address	9/16 et Babilin 50	nes, J	WINDSOR R Fun. 5	Mills Md
	Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused the death rone cause on each line.			such as cardiac	-	rrest,	Approximate Interval Between Onset and Death
8760,	be executed cien and purial-transit	sai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. PLACEMEN Due to (or as a consequence) C Due to (or as a consequence)	VT OI	= Biv	AD and	1 Coq	gulopathy	Chours
.O. Box 68	Attending Physician: The law requires that the death certificate rideath. sctor: Atter this certificate has been signed by the attending physisy the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ₩ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 ∐Live birth 2 ∏ Fetal 4 ∏ Pregnant at time of de 9 ☐ Unknown	death 3 □Ec	ctopic pregnancy ther (specify)	-		23d. Date of deliv Month	very Day Year
٥.	w requires that is been signed by should be detail	٥	Part II. Other significent conditions	contributing to death but not resu	Iting in the unde	orlying cause giver	in Part I.		obacco use contribute to Yes 2 \(\text{No} \) 3 \(\text{Pro}	
al Reco	n: The law ra ficete hes be or, page 2 sho	Completed	25. Was case referred to medical					1 ☐ Yes	osy ormed? prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 No
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	ation: To Be	xaminer? Xes 2 No	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	3 DOA Other 28c. Injury a Work?	4 🗆 Nui sirig Ho	me 5 Resid	one) dence 6 □Other (Speci now injury occurred	(y)
Divis	ital or Atterns after desiral Directoriled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined	building, etc. (Specify				City or Tov		
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in I	Medical	one)	hysician: To the best of my know minar: On the basis of examinati and manner stated.	riedge, death or on and/or inves	tigation, in my opii	nion, death occurr	ed at the time,	date and place, and due t	to the cause(s)
•			29b. Signature and title of certifier Place gac	completed cause of death (Item	20.15	29c. License			29d. Date signed (Month,	
72.8	<i>∰</i> Sta	te	30. Name and address of son who DANA CARA GAC 31. Date filed (Month, Day, Year)	completed cause of death (Item i ANU 100 HAR) 32. Registrar's Signate	23a) (Type, Prin BOR VIE ure	IN DRIVE	UNIT ?	714 BAG	LTIMORE A	1) 21230
	Registr	_	SFP1 5 2	200	L A	N.				

DHMH 17 Rev 1/2001

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State

Registrar

111 Penn Street Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 2005

32. Registrar's Signature

UNG LI

31. Date filed (Month, Day, Year)

521	15		For State	State of Ma	ryland / Dep	artment ertificate				, ,	00	005	0.0	
	_		Registrar 1. Decedent's Name (First, Middle, Las.	·)		Timeate	5 UI L	Jean		Date of Deat	eg. No. /	102	3. Time	of Death
	Physici		BRANDON ANTIWAN	LEE						Month EPTEMBI	ER 10,	2005	2121	РМ
	/Medic Examir		4a. Facility Name (If not institution, give			4b. City,	Town, or	Location of		<u> </u>	7	y of Death	2121	
1			UNIVERSITY HOSPITA	\mathbf{L}		BAL	CIMO	RE CI	TY					
	Funeral		Social Security Number 6. Se	x 7. Age XM 2□F	(In yrs. last birthday) If Under Months	1 Year Days	If Under :		Date of Birth (Month, Day,	Year)	9. Birthp	place (State	or Foreign
-	Director		217-98-7721 Usual Residence of Decedent	2	23				AF	PRIL 28	3,1982		MD	
	yland sow		10a. State 10b. County		10c. City, Town or L	ocation						1	0d. Inside	City Limits
	Mar	io	MD		BALTI	MORE							1 ∑ Ye	s 2 No
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ahow the Madigal Examere must be codified at	Director	10e. Street and Number			10f. Zip	Code			1	0g. Citizen of	What Cour	ntry?	
	ath w	rai	2746 MOSHER STRE			2	2121	6			USA			
	er de	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		Was Deced If Yes, spec	ent of Hi	ispanic Orig n, Mexican	gin? (Specify n, Puerto Rica	Yes or No- an, etc.)	14. Ra Bla	ce · Americack, White,	can Indian, etc.	
36	rs aft	by F	1 XNever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 📉 N If Yes, Give Year or Dates:	0	1 ☐ Yes 2	2 <mark>∑</mark> No	Specify:			Speci	fy:	117	
ဗို	2 hou	ted	15. Decedent's Edi	ucation		edent's Usua					16b. Kind of E	BLAC Business/In		
2	thin 7	pie	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5-	life.	B kind of wor DO NOT us	k done d e retired	during most)	t of working				,	
7	filed wil Hygien other th	Completed	12			TREPRE	ENEU					EMPLO	YED	
밀	be fill d oth	Be	17. Father's Name (First, Middle, Last)						,		Maiden Sumai	me)		
ž	should and Men a marke umatic	၉	CLEVELAND LEE 19a. Informant's Name/Relationship (T	una Printl	10h Mail	ing Address	(Ctrant of		NESSA		City or Town		2 11	
Z	nd 2 s aith an 27 ta r r traur		VANESSA ARTIS/MO			6 MOSH					MARY		2121	6
ē,	# # # # # # # # # # # # # # # # # # #		20a. Method of Disposition		20b. Place of Disp	osition (Nam	ne of	T	Date	TALK.	20c. Location			
Ë	Pages nent of int: If It iry or o		1 Surial 2 Cremation 3 II 4 Donation 5 Other (Specify,		WESTERN				9-17-	2005	BALTIM	ORE.	MARVI	.AND
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licens	ee				,		the second second	RTON &			
<u> </u>	89 = 28		James 9	· Moi	ten	1701-3	31 L/	AURENS	S ST.	BALTI	MORE,	MARYL	AND 2	1217
П			23a. Part 1 Enter the disease, or comp shock, or heart failure. List only o	lications that caused ne cause on each lin	the death. Do not er e.	nter the mode	of dying	g, such as	cardiac or re	spiratory arre	est,		Approxima Interval Be	etween
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. MULTIPL	E GUNSI	TOT	NO	SOUN				de l'angle	Onset and	Death
	/Medical Examiner		Toolsing in dozany	Due to (or as a	consequence of):									
Ţ		er	Sequentially list conditions,	b. Due to (or se s	nonegularica of):									
/	uted d ansit	Examiner	Sequentially list conditions, if any, loading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events											
ó	en en rial-tr		resulting in death) Last	Due to (or as a	consequence of):									
8760,	cate be executed obysicien end the burial-transit	dicai		d										
ğ	ertific ling pl	Med	IF FEMALE:		. 2010			÷.				Die.		
Вох	eath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth	2 ☐ Fetal death 3 l	□Ectopic pre						te of delive	ry Day	Year
o.	The law requires that the death certific ste hes been signed by the attending page 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant at t 9☐ Unknown	line or death 5	Other (spe	эспу)						,	
D .	s thet ned b	by PI	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the t	underlying ca	luse give	n in Part I.		23e. Did tob	acco use con	tribute to th	e cause of	death?
ğ	w requires been sign should be	ed b					_			1 🗆 Ye	s 2 00	3 Prob	ably 4 □)Unknown
Division of Vital Records,	law re es bea 2 sho	Completed								24a. Was ar		Were auto	sy findings	available
		Com								autopsy perform 12 Yes 2	red?	death?	npletion of 2□No	cause or
/ita	ysiclen: The is certificate he director, page	Be	25. Was case referred to medical examiner?				1		of Death (C)	neck only one	2			
ð	문 등 등	2	1 No 2 No 2 No 27. Manner of Death	Hospital: 1 Inpatier				4 🗆 Nur	-		nce 6 Oth		')	
no	ding h. After funer	tion	1 Natural 5 Pending	28a. Date of Injun (Month, Day)			Bc. Injury Work	at ? ∕es 2.√€N	(UBTEC	w injury occur		Kot	
isi	Attender: deat	fica	3 Suicide 6 Could not be		ry - At home, farm, st			2			eet and Numb		-	
ă	el or A	Certification;	4 Momicide determined	building, etc.	(Specify)	,					ASHBU			
	To the Hospitel or Attending Physician: within 24 hours elfer death. To the Funerel Director: After this certific; completely filled in by the funeral director.		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam)	sician: To the best of	f my knowledge, dear	th occurred a	it the tim	e, date and	diplace and	due to the ca	use/s) and m	anner as et	ated	
	To the Howithin 24 To the Forcempleter	Aedicai	0,10)	ner: On the basis of and manner stat	ed.				n occurred a					s)
	with To Con	Σ	29b. Signature and title of certifier	•		29c.	OCM	number			d. Date signe			
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	6		30. Name and address of person who co	NB10, M			ET :	RAT TT	MODE	ΜΛΡΥΤ Λ	VIII) 21	201		
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State

31. Date filed (Month, Day, Year) SEP 1 5 2005

32. Registrar's Signature

ORIGINAL

Registrar DHMH 17 Rev 1/2001

		1 - For State Registrar	State of Mar	yland /		irtment of H		d Mental Hy	giene 20	05	30058
Physicia /Medic	al .	1. Decedent's Name (First, Middle, Las SERANI 4a. Facility Name (If not institution, give	E LAU	TEI	NB	ENSE 4b. City, Town, o	17 ocation of De	2. Date of De Month	Day	Year	3. Time of Death
Examino Funeral Director		5. Social Security Number 6. Security Number 118–16–2221	41 Cent	In yrs. last t	birthday) Yrs.	If Under 1 Year Months Days	TIM (ME	fal;	9. Birthpla Count	ace (State or Foreign try)
a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Baltimor		Oc. City, To		cation					Od. Inside City Limits
s 23a or 28	Funerai Director	10e. Street and Number 1323 Chapel Street			1	10f. Zip Code 21237			10g. Citizen of W		
ours after de	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Tes 21 No If Yes, Give Year or Dates:	er in U.S.		Vas Decedent of H Yes, specify Cub	dispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No Jerto Rican, etc.)		e - America k, White, e -White	etc.
should be filed within 72 hours after death with the Maryland and Mental Hygiene. In a feet death with the Maryland marked other than 'natural', or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12th			(Give i life. [lent's Usual Occup kind of work done DO NOT use retire Cial Seci	during most of t d)	working	16b. Kind of Bu		ustry
y round ould be filed I Mental Hyg harked othe hatic evant,	To Be C	17. Father's Name (First, Middle, Last) Leopold Vanek					Amelia				
and 2 tealth a m 27 is		19a. Informant's Name/Relationship (7) David Lautenberge 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	er/son	80 20b. Place	00 Ro	g Address (Street DWEN Road sition (Name of natory or other place	Silve	Rural Route Numb er Spring Date		nd 2	0910
permit. Pages 1 Department of H Important: If ite any injury or of ance.		' 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen)	Dulan	22		ss of Facility	5/05 Cvach/Rose nue Rose		neral	. Home
Physician /Medical		23a. Part1. Enter the disease, or companies, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Pue to (or as a	CAP	o not ente	er the mode of dyin	ng, such as card		rrest,		Approximate Interval Between Onset and Death
cate be executed by sician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. The Due to (or as a control of the Control of th	NI	ی	LYMI	LUN	y tre	Leulur	n) A C	Mensur
Physician: The law requires that the death certifical this certificate has been signed by the attending phral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal dea		Ectopic pregnance	/		23d. Date Mon	of deliver	y Day Year
w requires that been signed by should be deta	þ	Part II. Other significant conditions of	ontributing to death but	not resulting	j in the un	nderlying cause giv	ren in Part I.		obacco use contri Yes 2□No	bute to the	ab.
ysician: The law re is certificate has be director, page 2 sho	Completed							24a. Was autoj perfo 1 🗆 Yes	ormed? pi	/ere autop rior to com eath? Yes 2	sy findings available apletion of cause of
fte in a	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of eath 1 Natural 5 Pending investigation	Hospital: Inpatient 28a. Date of Injury (Month, Day)	28b	Outpatient Time of Injury	28c. Injur Wor	er: 4 Nursin	Death Check on o g Home 5 Residence 1 28d. Describe I			
To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	building, etc.	(Specify)				City or Tou			
o the Hosp ithin 24 hor o the Fune	Medicai	29a. Certifier (Check only one) 2 Medicel Exemple of Certifier 29b. Signature and title of certifier	ysicien: To the best of liner: On the basis of e and manner state	xamination a	ge, death and/or inv	restigation, in my c	ppinion, death or	ace, and due to the ccurred at the time,	cause(s) and man date and place, a 29d. Date signed	nd due to t	the cause(s)
h = 1 = 5		30. m and address of person who	completed cause of dea	th (Item 23a	/M.	Print)	038	IMONE			
Şta Registr		31. Date filed (Month Day, Year)	al mp 30	s Signature	PX	upe	BALIT	IMONE	, MD	21	202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#9,10e,15,16a-b,17,18,19a-b,20a-c,22 perFH G847,9/22/05 TT State of Maryland Department of Health and Mental Hygierie Reg. No. 2005 1 - For State Registrar 30059 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) LEPPARD Month **Physician** ARENA 20:45 09 05 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Prince George's Medical Center Cheverly | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 7, 19 9. Birthplace (State or Foreign Country) **D.C.** 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 ☑ M 2 ☐ F Yrs 1914 Director 579-56-2873 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location itam 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Mexical Exercises must be notified at 1 Yes 2 No Washington DC Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20011 USA 5716 Second Street, NE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onen of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: black 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unk Clerk U.S. Government unk unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental Joseph Henry Dunahoo Eliza Williams ပ္ 19b Maijing Address (Street and Number or Rural Boute Number City or Town State Zin Code)

4601 Kane Place, NE Washington, It Z0019
3001 Hospital Drive Cheverly, MB 20785 19a. Informant's Name/Relationship (Type, Print) Henry J. Miller, Nephew Prince Coorge's Medical C f Health a 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its any injury or ot once. MD Nat'l Mem. Park 9/21/2005 Laurel, MD '4 □Donation 5 ♥Other (Specify) in State 22 Name and Address of Facility II. S. Washington & Sons Co. Inc Ronald S. Wade, pirector 4925 Burroughs Ave, NE 21201 Baltimore, MD Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Washington Apprecia 20019 shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final SER 51 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) ena 1 Examiner 2 tus4 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) ncepholo pothin Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 **X** No 1 ☐ Yes 2 ☐ No 1 ☐ Yes of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: Injury Division 1 SNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 24 hours a 29a. Certifier 🌠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the the within 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 em, 916105 D0059981 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRINCE Georgeis Hospital MUKEMII Abdella, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) SEP 1 5 2005 State Registrar

			For State Registrar	State	of Marylar		artment of H		d Mental Hyg	jiene _{leg. No.} 2	005	30	חבר		
			1. Decedent's Name (First, Middl	e, Last)					2. Date of Dea			3. Time of	Death		
	Physicia /Medic		Harry Sonny	Lady III	- 				Septenbe		2005	0335	- м		
	Examin		4a. Facility Name (If not institution		•		4b. City, Town, or		eath	4c. Count	ty of Death				
			Washington Co			for a A. fr. indiants of	Hager	stown If Under 24 F	dre la Data d'Allah		hingt				
	Funeral Director		5. Social Security Number 219-68-1018	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs.	Yrs.	Months Days		lin. (Month, Day	, Year)	Cou		r Foreign		
		1	Usual Residence of Decedent		46				Nov 10,	1930	Mary	Tand			
	how		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside Cit	•		
	e Ma	cto		ngton		Hage	rstown				1 ☐ Yes 2 ☐ No				
	or 24	Dire	10e. Street and Number				10f. Zip Code	7/0	1	log. Citizen of		ntry?			
	a 23e	rai	817 W. Washing			10 40 1		740	1/2	USA					
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. Item 27 ie marked other than "natural", or Itema 23s or 28s-f show other traumetic event, the Medical Examinar must be notified at	y Funeral Director	11. Marital Status 1 Never Married 2 Mar	Armed F ned 1 ☐ Yes If Yes, G	2 Mo ive No		Nas Decedent of H f Yes, specify Cuba I□Yes 2√2 No	Ispanic Origin? In, Mexican, Pu Specify:	? (Specify Yes or No- uerto Rican, etc.)	Bla	ice - Ameri ack, White, ^{ify:} Whj	etc.			
21215-0036	hour:	Completed by	3 ☐ Widowed 4 🛣 Divorced	Year or l	Dates:		lent's Usual Occup	ation							
7	In 72 In a	ojet	(Specify only highe	st grade completed		(Give	kind of work done of NOT use retired	during most of	working	16b. Kind of I	ousiness/ir	idustry			
212	with giene.	E O	Elementary/Secondary (0-12)		(1-4or 5+) O	d	isabled			none					
	e filed al Hygid other vent, I	BeC	17. Father's Name (First, Middle,	Last)				18. Mother's I	Name (First, Middle,	Maiden Suma	me)				
<u>a</u>	2 should be fand Mental I is marked of aumetic eve	To	Harry Sonny	Lady Jr				C	onnie Lou	Lauba1					
Maryland	2 shot and and le m		19a. Informant's Name/Relations						Rural Route Number						
	t and Heelth Sm 27 ther tu		Robert Lady/bro	other	20h I				Crt 8 Hage						
altimore,	Pages nent of H ant: If Ite		1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (5		State	cemetery, cren	sition (Name of natory or other plac	:8)	Date	20c. Location	- City or 10	own, State			
Balti	permit. Pages Depertment of Important: If It any injury or o		21. Signatur u sineral Service	Licensee S. Nade,	Directo				ard 655 W.	Baltin	nore S	Street			
			Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that capsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between												
	Physician		Immediate Cause (Final disease or condition	a.	ene	re	ane	eme	-8.			Opcet and D			
	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):	Pul	act	700			mon	ler		
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a consec	uerice of):	July 1	/	- 7	_		1100	4 6		
	xecute and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of);	DOST L	my	us	e	gen	18			
8760,	icate be executed physician and s the burial-transit	dical E		(G	norstro	mle	Stma	XX	Blee	1		Imos	Mis		
9		a	IF FEMALE:	($\overline{}$					
Вох	death certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live	tcome of pregn birth 2 ☐ Feta	al death 3	Ectopic pregnancy	,			ate of delivion	,	/ear		
o.	t the c by the	Physician/M	1 Yes 2 No 9 Unknown	9□ Unk	nant at time of o	Jea(II 5	Other (specify)								
S, D	res tha igned be del	by	Part II. Other significant conditi	ons contributing to	death but not re	sulting in the u	nderlying cause give	en in Part I.		bacco use cor					
Records,	w requir been si should	Completed	A CO10	77	100	vevi	143	311	- 1 Y	es 2 No	3 Prot	oably 4 □U	пкпоwп		
3ec	hes b	mpie		1-1-1			//		24a. Was a autops perform	Sy	. Were auto prior to co death?	psy findings a mpletion of ca	available ause of		
	icate			0						2 No	1 Yes	2 No			
Vital	siciar certif	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Name of		Oth	er	Death (Check only or						
o	g Phy er this eral d	\vdash	27. Manner of Farilin	28a. Date	of Injury	ER/Outpatien 28b. Time of			g Home 5 Resid			'y)			
<u>o</u>	ttending death. stor: Afte / the fun	atio	1 atural 5 Pendi 2 Accident invest	ng (Mo igation	nth, Day Year)	Injury		K? Yes 2 □ No							
Division of	l or Atte efter de Directo	Certification;	3 Suicide 6 Could 4 Homicide determ	280. Plac	e of Injury - At h ling, etc. (Speci	iome, farm, str ify)	eet, factory, office 28f. Location (Street and Number or Ru City or Town, State)					al Route Numb	ber,		
_	To the Hospital or Attending Physician: The within 24 hours effer death. To the Funeral Director: After this certificate hy completely filled in by the funeral director, page		(Checklonly 2 Medical	ng Physician: To the	e best of my knobasis of examina	owledge, death	n occurred at the time	ne, date and pl	ace, and due to the c	ause(s) and m	nanner as s	itated.)		
	the hin 24	Medicai	one) 29b. Signature and title of certific	and ma	nner stated.		29c. License			9d. Date sign					
	T with		250. Signature and title of certifi	(de	(M)		250. License	4 (7) 2	1	Sound	- 9 5	Day, rear)			
			30. Name and address of server	who complished be-	ISO Of don't //-	m 22c) //	Print)	000	4	regri	10	000	17		
			30. Name and address of person	51 AZ	2 d Q (77 (Type,	1944-0	les	(Cosson	2ff	2 H	からかん			
	Sta		31. Date filed (Month, Day, Year	32.	Registrar's Sign	atyre			/	/		1 1-1	-		
	Registi	ar	SEP 1 5 2005	Maria	D. S.				(

			1 - For State Registrar	State of N	Maryland		artment of H rtificate of		and Menta	al Hygier Reg. N	¥	5 20001
	Physici	an	Decedent's Name (First, Middle, La	st)					Mo	te of Death	ay Ye	ar 3. Time of Death
	/Medic	cal	OZEA	MORTON	-1		45 05 7		SEP		2005 ^{Ye}	
1	Examir	ner	4a. Facility Name (If not institution, give				4b. City, Town, o	r Location o		1	lc. County of E	Death
	Funeral		HARBORSIDE HEALT 5. Social Security Number 6.5		FUKD Age (In yrs. la:	st birthday)	If Under 1 Year	If Under 2		te of Birth	9.	Birthplace (State or Foreign
	Director		218-09-3702 Usual Residence of Decedent	1 XM 2□F 8	7	Yrs.	Months Days	Hours	Min. (Mo	te of Birth onth, Day, Yea NE I,	1918	Birthplace (State or Foreign Country) VA
	Marylan s-f show	tor	MD 10a. State 10b. County			Town or Lo						10d. Inside City Limits 1 → Yes 2 □ No
	3e or 284	i Direc	10e. Street and Number 1316 EDISON AVEN	UE			10f. Zip Code 21213	3			Citizen of What	t Country?
980	within 72 hours after death with the Maryland ane. than "naturel", or liems 23e or 28a-f show the Modical Exeminer must be notilled at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force: 1 Yes 2 If Yes, Give Year or Dates	s?]No		Was Decedent of H If Yes, specify Cub	lispanic Orig an, Mexican Specify:	gin? (Specify Ye i, Puerto Rican,	etc.)		American Indian, Vhite, etc. BLACK
21215-0036	ithin 72 ho ne. han "natu	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4o	r 5+)	(Give life. i	dent's Usual Occup kind of work done DO NOT use retire	oation during most d)	t of working		Kind of Busine	•
	filed w Hygier ther th		17. Father's Name (First, Middle, Last			MIL	L WORKER	10 Matha	r's Name (First,		ETH STE	CEL
Maryland	2 should be filed withlr and Mental Hygiene. Is marked other than eumatic event, the Ma	To Be	WILLIE MORTON						IARRIETT		,	
Mar	d 2 should be sh		19a. Informant's Name/Relationship				ng Address (Street					
Baltimore,	ges 1 and 2 should be filed within to f Health and Mental Hygiene. If item 27 Is marked other than or other treumatic event, If a M		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		e	ce of Dispo netery, crer	sition (Name of natory or other pla	ce)	Date	20c.	Location - City	or Town, State
altin	permit. Pages 1 Department of H Important; If ites any injury or oth		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		ρ ST.	y	SLAUS CE		9/15/200		LTIMORI	
Ä	permi Depa Impo any ir		James	a. Wfor	tin		701 LAUR				21217	SONS F.H., INC
	Physician /Medical Examiner	er.	23a. Part. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate.	aDue to (or a	line. SEP as a conseque	515 ence of):	er the mode of dyll	ng, such as t	cardiac or respi	ratory arrest,		Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	c	is a conseque							
.O. Box 6	that the death certific ed by the attending pl detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal d	death 3□	Ectopic pregnancy Other (specify)	4			23d. Date of Month	delivery Day Year
rds, P.	w requires that been signed b should be det		Part II. Other significant conditions DEM ENTI A	contributing to death	but not result	ting in the u	nderlying cause giv	ren in Part I.	23	e. Did tobacco		e to the cause of death? Probably 4 Unknown
Il Records,		Completed by								a. Was an autopsy performed?	death	
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			0.11		of Death (Chec			
of	ding Phys h. After this funeral di	tlon; To	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D		R/Outpatien 28b. Time of Injury	28c. Injur Wor	y at		Residence		Specify)
Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined	28e. Place of I	njury - At hom etc. <i>(Specify)</i>	ne, farm, str	eet, factory, office	.00 2	28f. Loc	cation (Street a y or Town, Sta	and Number or te)	Rural Route Number,
	he Hospitel or n 24 hours atte ne Funerel Dir bletely filled in I	Medical (29a. Certifier (Check only one) Certifying P 2 Medical Exa	nysician: To the bes miner: On the basis and manner:	of examination	ledge, death on and/or in	occurred at the tirvestigation, in my o	me, date and pinion, deat	d place, and due th occurred at th	to the cause(ne time, date ai	s) and manner nd place, and o	r as stated. due to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	ΛΛ	Ð		29c. Licens	e number				onth, Day, Year)
			30. Name and address of person who	/// -	death (Item 2	23a) (Tyne	Print)	058	457	SE	1/ rem	3ER 132005
	b		WANT CEASAR	- 821	YOUTH	t Ev		REE	7 BAZ	TIMO	16	21201
	Sta Registr	_	31. Date filed (Month SEAP Year) 5	2005 32. R	Mar's Signatu	The Land	booth					

Adam Mulbauer 05-06161 UNK Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. MLO State of Maryland / Department of Health and Mental Hygiene 2015

1- State Unpend Item 23a, 27, 28a-f per me G847 9-16-05 tas
Reg. No. 30062 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 8:05 September 8, 2005 MAGI /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 1300 Leadenhall Street Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex **Funeral** 1 M 2 F Months 213-94-8323 Usual Residence of Decedent 0-1-74 Director 10d. Inside City Limits the Maryland 10c. City. Town or Location 10a. State 10b. County show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director しろびか 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9 5.A. or Itams 23a 2035ING Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ res 2 ☐ No 11. Marital Status 1 Never Married 2 Married Yes, Give ear or Dates: 1448-2001 1 Yes 2 No Specify: WhITE Baltimore, Maryland 21215-0036 Specify. ģ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ERCHANDISING KEVERAGEL h and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be KIMBERLY BOC KICHARD NEWMAN Pages 1 and 2 should nent of Health and Men traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JANET RURDY, AUNT permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trat once. 78 Many in the Season Sing Community 2112 ace of Disposition (Name of Date 20c. Location - City or Tow 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 Scremation 3 □ Removal from State VIEW CREMATURY BALTIMORE, * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Licens 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Narcotic(Heroin) intoxication Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, as the IF FEMALE esn 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? detached for 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Records, P.O. 9 Unknown Š 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 2 No 3 Probably 4 Unknown 24a. Was an

Completed by Physician/Medical To Be Medical Certification:

25. Was case referred to medical examiner? 27. Manner of Death

ĭXXYes 2 No

1 Natural

2 Accident

3 🗌 Suicide

29a. Certifie

4 - Homicide

page 2 s certificate To the Hospital or Attending Physician: ē this death. Director: / within 24 hours a To the Funeral I pelli

Division of Vital

autopsy performed' 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of 2 No 'es

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Scene 28b. Time of unk 28c. Injury at Work? 28d. Describe how injury occurred unk Injury

Pound: 1 ☐ Yes 2 X No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Found in woods

Baltimore,

28f. Location (Street and Number or Rural Route Number. City or Town. State) 1300 Leadenhall St. Baltimore, MD

September 9, 2005

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

OCME

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year)

ARANIOCK

5 Pending

investigation

6X Could not be determined

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 11em 5 per fh 9847 9-27-05 vt. State of Maryland / Department of Health and Mental Hygiene 2005

30063 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** SEPTEMBER 11, 2005 HASKELL MILLER 3:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE WASHINGTON MEDICAL CENTER GLEN BURNIE ANNE ARUNDEL CO 8. Date of Birth (Month, Day, Year) Jan. 2, 1943 9. Birthplace (State or Foreign Country) West Virginia . Social Security Number **3253** 232–70–3250 6. Sex. 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Yrs. Director 62 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. fnside City Limits ir then "netural", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 809 223rd Street 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 19 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) Yellow Transportation Heavy Equiptment Mechanic permit. Pages 1 and 2 should be filed Depertment of Health and Mental Hyg Importent: If item 27 is marked other eny injury or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elliott Miller Beatrice Holcomb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah S. Miller (Wife) 809 223rd Street, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Bayview Crematory 09-16-05 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 21. Signature of Euneral Service Licensee OXATIL 23 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death mmediate Cause (Final of chronic alcohol asuse Complications Physician disease or condition resulting in death) /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknow sete has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an autopsy performed? 1XYes 2 No After this certification, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 █ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No 28a. Date of fnjury (Month, Day Year) 27. Manner of Death

1 Natural
2 Accident 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of al or Attending P s efter death. I Director: After t Certification: 5 Pending 1 ☐ Yes 2 ☐ No М investigation 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours of To the Funeral D 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainly as success.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. critifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME SEPTEMBER 11, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND, 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 1 5 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 1808 **Physician** MANNING September /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A HOSPITAL BALTIMORE JOHNS HOPPINS If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Date of Birth (Month, Day, Year)
July 31, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🖸 F 218-01-4838 1919 86 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic avairable. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 ¥ Yes 2 □ No Baltimore Maryland Director N/A 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code 21230 1700 Johnson Street USA Be Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Housewife & Mother 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Kairos George Violet Stanley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2305 Riverside Drive, Baltimore, Md. Mr. William Manning (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. Glen Burnie, Maryland 9/16/05 McCully-Polyniak Funeral Home, P.A. 130 E. Fort Ave., Baltimore, Md. 21. Signature of Funeral Service Licensee 21230-4513 an Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARRHYTHMIA CCARDIAC 2-3-MINUTES **Physician** /Medical Due to (or as a consequence of) **Examiner** FOR END STAGE REVAL DE Hemodialysis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit (CERE BROVASCULAR ACCIDENT The law requires that the death certificate be executed ERTERRO-Basilar Due to (or as a consequence of) Box 68760. 26 YEARS Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No jo 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2X No 1 Yes Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3□ DOA 2 this 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Natural 2 No death. 1 Tes 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier PETER LEARY MEDICAL TEMPER 12, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL LEARY JOHNS HOPKINS 32. Registral's Signarire 31. Date filed (Month, Day, Year) State 1 5 2005 Registrar

		1 - For State Registrar	State of Maryla	and / Dep	artment of Hea rtificate of Dea		Reg.	•	5 3006	
Physici /Medio Examir	al	4a. Facility Name (If not institution, gr	OSS ve street and number)		4b. City, Town, or Loca	ation of Death	2. Date of Death Month 08/25,	4c. County of Dec	20:57 M	
Funeral Director		083-22-1296	-	rs. last birthday, Yrs.		Jnder 24 Hrs. Durs Min.	8. Date of Birth (Month, Day, Yo June 22	9. Bi	Georges rthplace (State or Foreign country) NY	
e Maryland late of the state of	ctor	Usual Residence of Decedent 10a. State 10b. County MD Prince	Georges 10c.	City, Town or L	Laurel				10d. Inside City Limits 1 □ No.	
th with th 23a or 24 ist be no	ai Dire	10e. Street and Number 14200 Laurel	Park Drive		10f. Zip Code	20707	10g.	Citizen of What C	ountry?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, ir a Medical Examine must be notified at 20.66.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Vidowed 4 Divorced	1 □ Yes 2 🔀 No		Was Decedent of Hispan If Yes, specify Cuban, Me 1 ☐ Yes 2 ☑ No Sp	nic Origin? (Spe exican, Puerto pecify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:		
d within 72 ho piene. r than "natur Ine Medical	ompieted	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+) O	e completed) College (1-4or 5+) (Give kind of work don life. DO NOT use retire.			ng 161	E. Kind of Business	s/Industry arming	
uld be filed fental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Frank P. Green 18. Mother's Name (First, Middle, Maiden Sumame) Emma S. Pooler								
and 2 shou eaith and M m 27 is mai		19a. Informant's Name/Relationship Kenneth A. He	lmer / Son	Lot	ng Address (Street and N	Court,	Laurel Ma	aryland 2	20724	
it. Pages 1 rtment of H rtant: If itel njury or ott		20a. Method of Disposition 1 Burial 2 Cremation 3: 4 Donation 5 Other (Spec	Removal from State (ify)	cemetery, cre ural Par	osition (Name of matory or other place) rk Cemetery	8/3	iolos I		wait' by	
Depa Impo amy is		21. Slogature of Funeral Service	victor P. Doc	la,Jr.	arles L. St 01 E. Fort	evens F Avenue,	uneral Ho Baltimon	ome, Inc. re MD 212	230	
ate be executed //Medical Examiner and the buriar-transit	Examiner	shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisase) or injury that initiated events resulting in death) Last	a. Septionia Due to (or as a cons Due to (or as a cons Due to (or as a cons Conjectiv Due to (or as a cons	equence of): e Heart equence of):					Interval Between Onset and Death 2 weeks 2 weeks 1 year	
death certific e attending p ed for use as i	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2XXBo 9 □ Unknown	d. Coronary 23c. If yes, outcome of pree 1 Live birth 2 Fred Fred Fred Live by Unknown	gnancy etal death 3[Disease Ectopic pregnancy Other (specify)	23d. Date of de Month	2 years			
quires that the de n signed by the a uld be detached f	b	Parking one Spring and Continuous								
Physician: The law requires that the this certificate has been signed by the director, page 2 should be detached.	Completed									
Attending death. ctor: After y the funer	Certification; To Be	25. Was case referred to medical examiner? 1 Yes XXNo 27. Manner of Death 1 XNatural 5 Pending investigating in	28a. Date of Injury (Month, Day Year)	home, farm, st	ont 3 DOA Other 4 of 28c Injury at Work? M 1 Yes	□ Nursing Hon 2 2 □ No		njury occurred t and Number or R	ecify) tural Route Number,	
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	dical Cert	29a. Certifier 1 X Certifying P	hysician: To the best of my k	nowledge, deat	h occurred at the time, da	ate and place, a	city or Town, S	e(s) and manner a	s stated.	
To the i	Medi	29b. Signature and title of certifier	and manner stated. ATTEMP) PHYSICIF	1 G	29c. License num	1216	29d.	Date signed (Mon.	th, Day, Year)	
7		30. Name and address of person who	-D. L.R.11	-, 730	Print) O VAN DUS	en ru	LAUR	EL ms	20107	
Sta Registr		SEP 1 5 2	32. Fegistrar's Sig	nature	parti					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Pr., G847, 09/15/05dhb Reg. No. Reg. No. 005 Reg. No. Salvatore Michael Meola 2. Date of Deatt 08/29/2005 1. Decedent's Name (First, Middle, Last) Physician /Medical Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner last birthday 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Min M 2 F Director Usual Residence of Decedent 10c City, Town or Location should be filed within 72 hours after death with the Maryland 10a. State 10b. County or 28a-f shov other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1 Yes 2 No 10e Street and Number 10g. Citizen of What Country? items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. orces? 2 ☐ No 2 Married 1 Never Marries Baltimore, Maryland 21215-0036 1□ Yes @□No ò Specify: Yes, Give ear or Dates: 4 Divorced 3 Widowed "netural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nt of Health and Mental Hygiene.

If item 27 is marked other than '
or othar traumatic event, the Me Element (v/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle Be Name/Relation Pages 1 and 2 Ningsville 0a. Method of Dispo Cremation 3 R 1 Durial 3 Removal from State permit. Page Department of Important: If any injury or once. 4 Donation 21. Signature of Funeral Service Licenses 23a. Part Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 44eass 012 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown the funeral director, page 2 should Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Besidence 6 Other (Specify) Hospital: 1 Inpatient 1 Yes 2 Medical Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Division 5 Pending after death. 2 Accident 1 Yes investigation 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

20 Craiston

32. Registrar's Sign

5 2005

			For State Registrar	State o	f Maryland / De	epartmen Pertificate	t of H	lealth a Death	and M	ental Hyg	iene g. No. 2	005	301	067
	Physici	20	1. Decedent's Name (First, Middle	, Last)				_		2. Date of Deat Month	h Day	Year	3. Time of	Death
d	/Medic		Robert Eugene M							Septembe			1:00	PM M
)	Examin	er	4a. Facility Name (If not institution, Gilchrist Hospi	*	mber)			r Location o	of Death			4c. County of Death		
day gg	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last birtho		1 Year	If Under 2		8. Date of Birth		1timor	place (State or ntry)	r Foreian
	Director		215-22-4837	1 ₹ M 2 □ F	78 Yr	Months .	Days	Hours	Min.	(Month, Day, Sept 18	Year) • 1926	S Cou	hio	
- 4	pu k		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location							10d. fnside Cit	u Limita
	Maryla f eho	ō	MD		Balti								1√∑Yes	•
	289-	Directo	10e. Street and Number		2010	10f. Zip	Code			10	0g. Citizen o	of What Cou		
	h with	io ie	3715 Pinewood	Avenue				21206				USA		
	ems ?	Funerai	11. Marital Status		edent Ever in U.S.	13. Was Deced			gin? (Spe	cify Yes or No- Rican, etc.)		Race - Ameri Black, White,		
36	or it	by Fu	1 Never Married 2 Marri	ed 1 X Yes	2 No	1 ☐ Yes		Specify:		,	Spe		nite	
Ş	hour fure!	ed b	3 Widowed 4 Divorced		ates: 145-46	ecedent's Usua	I Occup	ation			16h Kind of	Business/In		
<u></u>	n n	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed)	(0)	give kind of wor fe. DO NOT us	rk done	during most	t of workir	ng	TOD. RING OF	Cusinessyn	loustry	
212	d with	E O	12	College (emical	engi	neer			chemi	ical c	ompany	
9	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f ehow atto event, the Modical Exercical result be notilled at	Be	17. Father's Name (First, Middle, I							(First, Middle, M		,		
<u> </u>	Men Marke Marke	ပ္	Lawrence Edwa				12			celia F				
<u>a</u>	d 2 st th and 7 ts n treun		19a. Informant's Name/Relationsh Myra Mason/sp							Route Number, altimore		vn, State, Zij 2120		
ē,	Heall Heall tem 2		20a. Method of Disposition		20b. Place of D	isposition (Nan	ne of	-		-		n - City or T	own, State	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel; or items 23a or 28a-f show any injury or other treumstic event, the Macinal Examination and the notified at once.		1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (St	oecify)	State	crematory or o								
Ba	Depermit important in important in important in important in		21. Squatur of Funeral Service I	Wade,	Sitector	State A Baltimo				655 W.	Balti	more S	Street	
ı			23a. Park. Enter the disease, or shock or heart failure. List		Approximate Interval Bety	veen								
4	Physician		Immediate Cause (Final disease or condition	_a. !!!	Mastatic	black	der	ca	mc	er			Onset and D	tus
	/Medical Examiner		resulting in death)	Due to	(or as a consequence of)	:								
		- G	Sequentially list conditions if any, leading to immediate	b. Due to	(or as a consequence of	:								
	uted d ansit	Examiner	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
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9	entifica ling pt e as t	Med	IF FEMALE:											
Box	The law requires that the death certificate be executed as been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live I	tcome of pregnancy pirth 2 Fetal death nant at time of death	3 ☐ Ectopic pro	,			23d. Date of delivery Month Day Year				
<u>о</u> .	that the de led by the a detached t	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkn		3 🗆 Ottier (ap	oc.,y/							
	s that ned b e deta	by Pt	Part II. Other significant condition	ns contributing to d	eath but not resulting in t	ne underlying c	ause giv	en in Part I.		23e. Did tobacco use contribute to the cause of death'				
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œ		Completed								perform	ned?	death?	2□ No	430 01
<u>Sita</u>	ilcian: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			1 04		of Death	Check only on	9)		1	
Division of Vital Records,	Physician: r this certificantal director, i	J.	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 28a. Date		atient 3 DC	- 1	4 🗀 140		ne 5 Reside		Other (Special	NOSC	XLE
o	ding th. After	tlon	1 Accident 5 Pendin	g (Mon	th, Day Year) Inji	iry M	8c. Injur Wor 1 □	k? Yes 2 ∐!	_	od. Describe no	w injury occ	Julieu		
Visi	Attanding ir death. ector: After by the fune	ifica	3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place	of Injury - At home, farm	, street, factory	, office		2	8f. Location (St	reet and Nu	mber or Rur	al Route Numb	
۵	tal or A s after ei Dire ed in b	Certification:	4 🗆 Nomicide	bulld	ing, etc. <i>(Specify)</i>					City or Town	, State)			
	To the Hospital or Attanding I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edicai	29a. Certifier Check only one) Medical	Examiner: On the b	e best of my knowledge, asis of examination and/ ner stated.	death occurred or investigation,	at the tin , in my o	ne, date an pinion, deat	d place, a	and due to the ca ed at the time, da	use(s) and ate and plac	manner as se, and due t	stated. o the cause(s)	
1	within To the	W	29b. Signature and title of certifier	in la	m			e number	2	8	enten	ned (Month.	Day, Year) 200.	5
			30. Name and address of person	A P	se of death (Item 23a) (T	ype, Print)	P1	1. 1.	, (8 TO	NSIA	1 m	0 2/20	
10	Sta	ate.	31. Date filed (Month, Day, Year)	104/05 32.F	Registrar's Signature	(,0,	W	unce	4 1	10	4 - 07		/	
27	Regist		SEP 1 5 2	005	100 B A	and .								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** MICHELSOHN GOLDA SAHAVA 2005 extentes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6. Sex 9 Baltimore Baltimore N/A Mospital Sinoui If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. SEPT. 22 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** CZECHOSLOVAKIA 1 □ M 2 □ F 82 085-30-1589 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No BALTIMORE N/A Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21208 7301 PARK HEIGHTS AVENUE #203 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. , or items 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other trees. 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be FEURWERKER WEISS SARA ZEEV ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7301 PARK HEIGHTS AVE. #203 - BALTIMORE, MD 21208 HELMUTH MICHELSOHN / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SHAAREI ZION CEMETERY 9/14/2005 ROSEDALE, MD *4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licer 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final otic shock **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): vavasaclar Cogulation Examiner semina Sequentially fish conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 2 3 Probably 4 □Unknown 1 ☐ Yes 2 ☑ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1□ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examine Other: 4 Nursing Home Hospital: 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient 2 this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours e To the cause (s) and manner as stated. 29a Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier stember -000 completed cause of death (Item 23a) (Type, Print) **F**egistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Sahav a Michel

		1	For State Registrar	State of M	aryland / De <i>C</i>	partmer ertifica			nd M		giene Reg. No.	2005	30069
			Decedent's Name (First, Middle, L	ast)						2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physicia /Medic	_	FRANCES LAURA PI	ASZYNSKI					5	Septemb	er 1	2, 2005	5:30PM
	Examin		4a. Fecility Name (If not institution, go	ve street and number)			Town, or Lo		Death			County of Death	
			Heritage Genesis		ome e (In yrs. last birthd		timore	e If Under 24	4 Hrs.	8. Date of Birtl	h	altimore	place (State or Foreign
	Funeral Director		5. Social Security Number 6. 219-01-6284	Sex 7. Ag 1 M 2 XF 7. Ag	84 Yrs	Months	Months Days Hours Min. (Month, Day, Year) 11/15/1920						yland
			Usual Residence of Decedent										
	how		10a. State 10b. County		10c. City, Town o	r Location							10d. Inside City Limits
	Ba-f s	cto	MD Baltimor	e	Essex						10 00		
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itema 23a or 28a-f show ther than "natural", or Itema 23a or 28a-f show ant, the Medical Examiner must be notified at	Funeral Director	813 Middlesex Ro	oad			p Code SSEX				Balt	zen of What Col	
	or dea	nue	11. Marital Status	12. Was Decedent Armed Forces		3. Was Dece If Yes, spe	dent of Hisp ecify Cuban,	anic Origi Mexican,	in? (Spe Puerto f	cify Yes or No- Rican, etc.)		 Race - Amer Black, White 	
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □ Yes 2 🔯 If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☐ No Specify: Sp							.te
21215-0036	2 hou	Completed by	15. Decedent's	Education	16a. De	ecedent's Usi	al Occupation	on	of morkin	100	16b. Ki	nd of Business/l	ndustry
215	Pin 7:	pie	(Specify only highest g	College (1-4or	In	(Give kind of work done during most of working life. DO NOT use retired)							
2	ad wit	Com	8th		Hor	nemake				/e*:		Home	
g	ifal Hydoth	Be	17. Father's Name (First, Middle, Lat							(First, Middle, alcerza		Sumame)	
<u>ya</u>	d Men narke	ဥ	Unknown Unknown 19a, Informant's Name/Relationship		19h M	ailing Addres						r Town, State, Z	in Code)
, Maryland	and 2 shealth and 2 7 ls r		Joan Davis/daugh		813	Middle	esex R	Road	Ess	ex, Mar	cyla	nd 2122	21
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menfait Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-1 show any injury or other traumetic event, the Mudical Examinat must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Control		20b. Place of D cemetery, Holly H:				⁰ 9/15	/05 E		imore, N	Town, State Maryland
Balti	permit. Departm Imports any inju		21. Signature of Funeral Service Lic	ensee	\		ind Address Chesac			ch/Rose		e Funera , MD 2	al Home 1237
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause by one cause on each	d the death. Do not ine.	enter the mo	de of dying,	such as c	ardiac o	r respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)										
	/Medical		resulting in death)	Due to (or a	a consequence of)	Λι	Mis	, 0=	=0		10	101	ONFARC
	Examiner	L	Sequentially list conditions, if any, leading to immediate	b. <u>E.S.</u>	a consequence of)	HL	H	111	1	1 EI	45	SIVIV	Zo JUNIO
	nsit	nine	Cause (Disease or injury	a consequence or,	•		(
	death certificate be executed attending physician and of for use as the burial-transit	Examiner	that initiated events resulting in death) Last	a consequence of)	:								
8760,	sicial ysicial e buri												
9	rtificat ng phy as th	ledi	IC CCMALC.										
Вох	eath certific attending pl	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic pregnancy					23d. Date of delivery Month Day Year		
	ie dea the at hed fo	Physician/Medical	1 Ves 2 No	4□Pregnant a 9□Unknown	at time of death	5 Other (specify)						
P.0	The law requires that the de ate has been signed by the s page 2 should be detached t			s contributing to death but not resulting in the underlying cause given in Part I.					23e. Did to	obacco u	ise contribute to	the cause of death?	
ds,	uires signo	d by	SENILE	DEN	1 FKT	FIA				1	Yes 2	□No 3□Pr	obably 4 Unknown
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Re	The lar	d mo								autor perfo	osy rmed? 2 No	death?	completion of cause of 2 No
tal		a	25. Was case referred to medical	14-0				26. Place	of Death	(Check only o			
f V	d s	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpat	ient 2 ER/Outp	atient 3 🗆 🛭	Other	4 Nur	rsing Ho	ne 5 🗆 Resid	dence	6 □Other (Spe	cify)
n of			27. Manr of Death 1 Natural 5 □ Pending	28a. Date of In (Month, D	ury 28b. Tin ay Year) Inju	ıry	28c. Injury a Work?	_		28d. Describe I	how inju	ry occurred	
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Division	2 ± ± ∈	Certification;	4 Homicide determin	ed 200. Place of the building, of	njury - At home, farm atc. <i>(Specify)</i>	i, street, iact	ry, onice			City or To	wn, State)	
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai C	(Check only 2 Medical E)	Physician: To the bestaminer: On the basis	of examination and/	death occurre or investigation	d at the time on, in my opi	, date and nion, deatl	d place, a	and due to the ed at the time,	cause(s) date and	and manner as d place, and due	stated. to the cause(s)
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Med	29b. Signature and title of certifier	and manner s	trated.	2	9c License	number	Gr		29d. Da	te signed (Monti	n, Day, Year)
•	10	1		no confolicidado de Co	day (1) Andra-la	do Drines	410	Δ	RT.	TCH	11	1715	HWAY
	4		The	no completed clusted	deth (II pro 23a) (T	TIMO	PE.	MF	FB	YLAN	(A)	212	25.
2	St Regist	ate trar	31. Date filed (Month, Day, Year) SEP 1 5		trar's Signature	1	, /	'		(, , ,	المبيلت -		
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ORIGINAL

			FOR	ate of Maryland / (20070	
			State Registrer	1	Certificate of D		Reg.	No. 2005	30070	
П	Physicia /Medic	an al	+ Decedent's Name (Eist, Middle, Last)	d reak		(Month	PT 8005	1338 M	
H	Examin	er	Aa. Facility Name (If not institution, give street	t and number)	4b. City, Town, or	Location of Death		4c. County of Death		
	Funeral Director		5. Social Security Number 6. Sey 213-60-4344	2□ F 7. Age (Irl yrs last bii	rthday) If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Ye	ary Cour	elace (State or Foreign http) Land	
	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	m or Location			1	Od. Inside City Limits	
	8e-1 s) U	Maryland Harford	Fore	est Hill		100	Citizen of What Cour	1 ☐ Yes 2 ☑ No	
	h with ti	ai Dire	10e. Street and Number 516 Rock Spring Chu	rch Road	10f. Zip Code 210	50	10g.	USA	itry :	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptygene. Important: If Itam 27 is marked other than "neturel", or Items 23a or 28a-f show any injury or other traumette avant. The Medical Eractified must be inclified. A QDCB.	by Funeral	1 Never Married 25 Married	Nas Decedent Ever in U.S. Armed Forces? Tyes 257 No fyes, Give Year or Dates:	13. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2√2 No	spanic Origin? (Specif n, Mexican, Puerto Ric Specify:	y Yes or No- can, etc.)	14. Race - Americ Black, White, Specify: Wh		
Maryland 21215-0036	ithin 72 hour ne. han "neturel Medical E.	Completed t	15. Decedent's Education (Specify only highest grade co	on 16a mpleted) College (1-4or 5+)	Decedent's Usual Occupa (Give kind of work done d life. DO NOTUSE relired) BUSING	uring most of working		Kind of Business/In	dustry	
7	lled w tygier her th		17. Father's Name (First, Middle, Last)	2 De	evelopment Co	ordinator 18. Mother's Name (Banking		
anc	ld be fi ental F ked ot ic avai	To Be	Paul Woodrow Peak			Ruth Mae		,		
ary	shou and M s mar		19a. Informant's Name/Relationship (Type,		o. Mailing Address (Street a					
Σ	and 2 lealth i m 27 i		Debra S. Peak/Wife		516 Rock Spri	ng Church		rest Hill Location - City or To		
Baltimore,	Pages 1 ment of P tant: If Ita jury or ot		20a. Method of Disposition 1 ☆Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	oval from State cemete	ery, crematory or other place ce UMC Cemete	ry 9-16-0		prest Hill		
Ball	Departiment Depart		21. Signature of Funeral Service Licensee	lexals	McComas Fu	neral Home	P.A.	ap 210	no.	
	Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one commediate Cause (Final disease or condition	ause on each line.	1317 Cokes not enter the mode of dying artary disc	g, such as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequence						
/	ted nsit	Examiner	Sequentially list conditions, by the list conditions, by the list cause. Enter Underlying Cause (Disease or injury	Due to for as a consequence	of):					
8760,	cate be executed physician and s the burial-transit	ai Exa	that initiated events resulting in death) Last	Due to (or as a consequence						
687	ifficate g phys as the	ledicai	d							
.O. Box	the death certific y the attending p tched for use as	Physician/Me	in the past 12 months?	If yes, outcome of pregnancy 1□Live birth 2□Fetal deatl 4□Pregnant at time of death 9□Unknown	h 3 Ectopic pregnancy 5 Other (specify)			23d. Date of delive Month	ery Day Year	
<u>α</u>	that ed b deta	by	Part II. Dther significant conditions contrib	uting to death but not resulting	in the underlying cause give	on in Part I.	23e. Did tobacco use contribute to the cause of death			
Division of Vital Records,	sician: The law requires certificate has been sign irector, page 2 should be	Completed					24a. Was an autopsy performed	prior to co death?	psy findings available mpletion of cause of	
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o	this ald	. To			outpatient 312 DOA Other	4 Nursing Home	5 Residence	e 6 Other (Specification)	y)	
lon	ding After fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury Work			.,		
Divis	는 # F	Certification;	3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory, office	28	f. Location (Stree City or Town, S	t and Number or Rura tate)	il Route Number,	
	To the Hospitel within 24 hours a To the Funeral Completely filled	edical (29a. Certifier 1 Certifying Physici (Check only one) 2 Medical Examiner	an: To the best of my knowledge On the basis of examination a and manner stated.	ge, death occurred at the tim nd/or investigation, in my op	e, date and place, an pinion, death occurred	d due to the caus at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)	
)	To the within 2 To tha comple	Me	29b. Signature and title at certifier		29c. License	4170		Date signed (Month, Ptember 11		
	20		30. Name and address of person who comp	Carano CL	B. Ilinamo	MD 75	201			
7		ate*	31. Date filed (Month, Day, Year)	32. Registrar's Signature	A	, , , ,				
DI	Regist	igi	SEP 1 5 200	D Server D	- About					

			Please		and / Department of		-	•	
			For State	State of Maryla	and / Department of <i>Certificate of</i>			2005	30071
			Registrar 1. Decedent's Name (First, Middle, Las	1)	- Commodio of		Reg. No Date of Death	5 0 0 0	3. Time of Death
	Physici /Medi		MARY L.	RINKLE			nonth Da		3:40 PM
	Examir		4a. Facility Name (If not institution, give	1 1/1	4b. City, Town,	or Location of Death	40	. County of Death	0 (
			Baltimore Woshin		center Glen	Burnie		thre Ar	undel
	Funeral Director		5. Social Security Number 6. Security Number 220–20–4135	7. Age (In y	74 Yrs. If Under 1 Yea Months Days	r If Under 24 Hrs. 8. E	Date of Birth Month, Day, Year, in. 09 19	9. Birthpla Countr	ace (State or Foreign and
			Usual Residence of Decedent			Ja	09 19	JI IIdiyi	
	anylan ahow	_	Md. 10b. County n/8	10c.	City, Town or Location Baltimore			100	d. Inside City Limits 1 X Yes 2 □ No
7	/ ith the Marylar or 28m-f show	ecto			10/ 7/- 0-1-		40- 0	**	
D	urs after deeth with the Maryland at, or itema 23s or 28s-f show Exeminer must be notified at	by Funeral Director	10e. Street and Number 1403 Webster St:	reet.	10f. Zip Code 2123		log. Ci	tizen of What Countr U.S.A.	y ?
I	deeth ma 23	Jera	11. Marital Status	12. Was Decedent Ever in	n U.S. 13. Was Decedent of	Hispanic Origin? (Specify ban, Mexican, Puerto Rica	Yes or No-	14. Race - America	
-49	after or ite	T.	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X	1 ☐ Yes 21 No		n, etc.)	Black, White, et Specify: whit	
ಕ್ಷಿ ಜಿ	within 72 hours after ene. then "neturel", or ite	d by	3 🕅 Widowed 4 □ Divorced	Year or Dates:					
	in 72 in 72 in at	oiete	15. Decedent's Ed (Specify only highest grad	de completed)	16a. Decedent's Usual Occu (Give kind of work don- life. DO NOT use retir	upation e during most of working red)	16b. K	(ind of Business/Indu	stry
212	d with giene. ir than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Proof Reader		Di	iamond Inc	
~ -) B	be filed with ital Hygiene. d other thereward, the	Bec	17. Father's Name (First, Middle, Last)		unknown	18. Mother's Name (Fire Mary	st, Middle, Maider L .	Sumame) Born	
Marylar		2				1			
Š	s 1 and 2 should f Health and Mer ttam 27 la marke othar traumatic		19a. Informant's Name/Relationship (7 Joseph E. Ruff	(Friend) 1315 Webster	r Street, Bal	ute Number City o Ltimore,	oMd. 21230	(ode)
ن	s 1 and 2 of Health Itam 27 other tra		20a. Method of Disposition	201	p. Place of Disposition (Name of cemetery, crematory or other pl	Date	20c. L	ocation - City or Tow	n, State
Baltimore.			1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other, (Specify	TOTTO VALUE OLATO	Cedar Hill Cemet	ery 09/16/0	5 Bai	ltimore, N	1d.
a	permit. Page Depertment of Important: If any injury or		21. Signature of Funeral Service Licens	00	22. Name and Addi	ress of Facility y-Polyniak F	unoral H	ome P A	
-	202		Jan 1	1 Jann	130 E eath. Do not enter the mode of dy	Fort Ave. B	altimore	_Md_ 2123	30
			shock, or heart failure. List only o	ne consequence of the displacement of the consequence of the consequen	- + 1			1	Approximate nterval Between Onset and Death
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687	that the death certificate ed by the attending phys detached for use as the	edic		d. 101 107 C	II Ca Col				
Box 68	h certi	M/ul	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ F				23d. Date of delivery	,
B	e deat	sicia	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of				Month D	ay Year
9	hat the d by t	by Physician/Medi	9 ☐ Unknown Part II. Other significant conditions co		resulting in the underlying cause of	mon in Part I	23a Did tobacco	use contribute to the	agues of death?
Division of Vital Records. P.O.	uires t signe Id be	d by	Takin out of organical containing of	with butting to doubt but not	resoluting in the dilicentying cause g	voicint Parti.		44	bly 4 Unknown
jo	The law requires ate has been signipage 2 should be	Completed					24a. Was an	24b. Were autops	sy findings available
Be	The la	шо					autopsy performed?	prior to complete death?	pletion of cause of
<u>fa</u>	ian: artifica ctor, p	BeC	25. Was case referred to medical examiner?			26. Place of Death Ch		10,165 2	No
) }	hysic this ce al dire	၉	1 ☐ Yes 💆 No		LI LIVOULDALIBITE 3 DOA	ther: 4 Nursing Home			
o uc	ding Physician: h After this certific tuneral director,	ion:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year		ury at 28d. l ork? ☐ Yes 2 ☐ No	Describe how inju	ry occurred	
isi	Attand deatl ctor: y the	fical	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - A	t home, farm, street, factory, office		ocation (Street ar	nd Number or Rural I	Route Number.
Ď	el or safter	Certification:	4 Homicide determined	building, etc. (Spe	ecify)		City or Town, State	θ)	
	To the Hospitel or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: Alter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	cal	29a, Certifier 1 Certifying Phy (Check only 2 Medical Exam	reiniam: To the best of my liner: On the basis of exam	knowledge death occurred at the innation and/or investigation, in my	nine, date and place, and d	lue to the cause(s) and manner as stated	(6d,
	the It	Medical	29b. Signaturejand title of certifier	and manner stated.		nse number			
	T wit		250. Signatural and sittle of certained	116		032744		ite signed (Month, Da	
	1		30. Name and address of gers 1 who d	ompleted cause of death ()	tem 23a) (Type, Print)		,	Hember	12 2007
	10		Marie Gaviria	a 301 F	Hospital Drive,	Glen Burnie,	Md. 210	61	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature				
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State of Maryland / Department of Health and Mental Hygiene For Stata Registrar 30072 Certificate of Death Reg. No. egdent's Name (First, Middle, 2 Date of Death 3. Time of Death Year **Physician** 2:30 AM Sept 2005 13 /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Me 7. Age (In yrs. last birthday) If Unde 5. Social Security Number Birthplace (State or Foreign **Funeral** 1 M 2 KF Months Days Director DOWLA Usual Residence of Decedent with the Maryland 10a State 10b. County City, Town or Location 10d. Inside City Limits in then "natural", or itema 23a or 28a-f show the Medical Examinat must be notified at 1 Yes 2 No MI Directo imore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 818 11. Marital Status filed within 72 hours after death Funerai as Decedent Ever in U.
med Forces?
Yes No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Yes Yes, Give ☐ Never Married 2☐ Married 1 Yes 2 06 Baltimore, Maryland 21215-0036 Specify. þ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use etired) 5. Decedent's Education only highest grade completed) 16b. Kind of Business/Industry al Hygiene. ry (0-12) College (1-4or 5+) perrit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If tem 27 is marked other any injury or other traumatic event, once. 17. Father's (First, Middle, Last) me (Firs<u>t, Middle,</u> Maiden Sumame) Rural Route Number, City or Town, State, Zip Code) 21234 Informant's Name/Relationshi 19b. Mailing Address (Street and S 2 Place of Disposition cemetery, cremator 20a. Method of Disposition 1 Burial 2 remation 3 Removal from State
4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the sease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death dying, Juch as cardiac or respiratory arrest, Immediate Cause (Final Physician day Due to (or as a consequence of): Bowe resulting in death) /Medical Examiner Se PSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury sequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last the attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy ğ Month Day Year 5 Other (specify) 4 Pregnant at time of death detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 4 Unknown 3 Probably 1 ☐ Yes 2 No Completed 24a. Was an autopsy performed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? has certificate 2 12 No 1 Yes Be 25. Was case referred to medical 26. Place of Death [Check only one] examiner Hospital: Other: မ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After t 1 Natural Injury 5 Pending death. 2 No 2 Accident investigation 1 ☐ Yes Director: 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide nin 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai CHOCK ONLY one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT 2438946-F33 MD Sept. I3, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ch nion Memorial Nandi Ksi MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** 955 AM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CO/112519 Counts if Under 24 Hrs. 8. Date of Birth (Month, Dey. If Under 1 Year 6. Sex 7. Age (In vrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours 017.18.8027 84 Deys 1X M 2□ F Yrs. Director March 17,1921 Fall River, MA Usuel Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Heelth and Mental Hygiene.
int: If flem 27 is marked other than "natural", or items 23s or 28s-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Md Howard Columbia Director 1 ☐ Yes 2 ☐ XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5632 Vantage Point Rd. 21044 USA Funerai 12. Was Decedent Ever in U,S. Amed Forces? 1 A Yes 2 □ No If Yes, Give 1942-1952 Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Be Completed by Specify: White 3 X Widowed 4 □ Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Phillatalic Specialist US Postal Service 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Raposa Elvira Souza 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Mongello- Daughter 5465 Delphinium Ct. Columbia, Md 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ō Columbia Memorial Park 9 16 05 Clarksville, Md 4 ☐ Donation 5 ☐ Other (Specify) any injury 22. Name end Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 5555 Twin Knolls Rd. Columbia, Md 21045 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physiclan/Medical Examiner within 24 hours efter deeth. To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the bunal-trensit or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, riangleSequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Š Be Completed 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Was en autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 27 No 2ER/Outpetient Medical Certification: To 3□ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner es stated. 2 | Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. To the 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30/Rame end address of person who completed cause of deeth (Item 23e) (Type, Print) Kazlow MA 10805 HICKORS 31. Date filed (Month, Day, 32. Registrer's Signature State

Registrar

			1 - For State Registrar	State of Ma	arylan	d / Depa	artmen rtificate	t of H e of L	ealth a	and M	lental Hy	giene 2	005	30074
4	Physici		Decedent's Name (First, Middle, Lass Jean Sou								2. Date of De. Month Septem	Day	2005	3. Time of Death 21:15 M
	/Medi Examir		4a. Facility Name (If not institution, give Calvert Memorial						Location of		ς	4c. Cour	nty of Death	<u>ب</u>
	Funeral Director		5. Social Security Number 020–20–1061 10 Usual Residence of Decedent	7. Ag	e (In yrs. 78	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month Da May 20,]	h 927 927	9. Birth Coul West	place (State or Foreign port, MA
	e Maryland a-f ehow	ctor	10a. State 10b. County MD Calvert			y, Town or Lo rince		rick					1	1
	h with th	al Director	10e. Street and Number 2035 Jessica La	ne			10f. Zip	Code 0678				10g. Citizen o	f What Coul	ntry?
9800	72 hours after death with the Maryland 'neturel', or items 23s or 28s-f ehow digst Examinat must be notified at	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 MeWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 King If Yes, Give Year or Dates:			Was Deced	offy Cubar	spanic Ori n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	8	ace - Americ lack, White, hify: Whi	etc.
21215-0036	d within giene. r then	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		i+)	(Give	dent's Usua kind of woi DO NOT us SSEMD	rk done d se retired)	uring most	of worki	ng	16b. Kind of	Business/In	,
Maryland	d be anta	To Be C	17. Father's Name (First, Middle, Last) Arthur: L	apre						Mabe		eau		
	47 tre		19a. Informant's Name/Relationship (T) Barbara Drum /								ince Fr			
Baltimore,	permit. Pages 1 and Department of Healt Importent: If Item 2 eny injury or other once.		20a. Method of Disposition 1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify,	lemoval from State	C	lace of Dispo emetery, crer yview Cr	natory or of	ther place	9) 5	ept. 2005	9,	20c. Location	100	own, State
Ball	Departiment Important in once.		21. Signatur of Funeral Service Licens	99		22	Charle 1501 E	d Address S L. Dast F	s of Facility Stever ort An	y ns Fur ne Bal	neral Hom Ltimore M	e Inc. D 21230		
7	Physician /Medical Examiner		23a. Part1. Enter the disease, of comp shock, or heart failure. List only of timediate Cause (Final disease or condition resulting in death)	Due to (or as	16.	CH F	er the mode	e of dying	, such as	cardiac c	r respiratory ar	rest,		Approximate Interval Between Onset and Death
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P.O. Box 68	death certific e attending p id for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pre Other (spe						ate of delive	ory Day Year
	law requires that the as been signed by th 2 should be detache	ρ	Part II. Other significant conditions co	ntributing to death be	ut not resu	ulting in the u	nderlying ca	ause give	n in Part I.			bacco use co es 2 \(\text{No} \)		e cause of death?
	The ate h page	Completed									24a. Was a autop perfor	sy	Were autoprior to condeath?	psy findings available inpletion of cause of
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	nt 2 🗆	ER/Outpatien	t 3 DO	Othe	-		(Check only on		has (Casa)	
sion of	Attending Phr r death. ector: After thi by the funeral	atlon: T	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	у	28b. Time of Injury		Bc. Injury Work		2	8d. Describe h			')
Divis	i Diffe	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	c. (Specify	/) 					City or Tow	n, State)		Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 ♥ Certifying Phy (Check only one)	sician: To the best oner: On the basis of and manner sta	examinat	wledge, death tion and/or inv	occurred a	at the time in my opi	e, date and nion, deat	f place, a	and due to the co	ause(s) and n late and place	nanner as st , and due to	ated. the cause(s)
	To the within To the comp	Σ	29b. Signature and title of certifier SWA					License	number	90	2	29d. Date sign	ed (Month, I	• •
1.	37		30. Name and address of person who co			23a) (Type, +105p	Print)	D	Proi	пи	fred	levian	MD	20678
24	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 5 20	32. Pogiistra	ar's Signat	ture	all							

State of Maryland / Department of Health and Mental Hygiene 200530075 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death CFILMAN AUG UST Physician LORETTA 6:30 AM 20 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Homewood Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2₩F Months 407-52-9306 Director Dec 11, Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is markad other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Director 1. Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6000 Bellona Avenue 21212 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene. Is markad other than "natural", or Iter 1 Never Married 2 ☐ Married ☐Yes 2√ No Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white à If Yes, Give 22 Year or Dates: 3 ☐ Widowed 4 ☐ Divorced unk πnk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) ont of Health and N.
Artant: if item 27 is
ny injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6000 Bellona Avenue Baltimore, MD 21212 19a. Informant's Name/Relationship (Type, Print) 6000 Bellona Avenue Baltimore, MD Genesis Homewood 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itel
any injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ♥ Other (Specify) in state Rorald S. Wade State Anatomy Board 655 W. Baltimore Street 23a. Part1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEVERE DEMENTIA Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CEREBELLAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? 2 No 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. Funeral Diractor: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier To the To the To the I and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0061789 SEPTEMBER 7, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOPEPINE OFFIL AWVAH, STOI LOCH RAVEN BLVD. BALTIMORE NO 21239 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 5 2005 Registrar DERECKES

DHMH 17 Rev 1/2001

			For State Registrar	State of M	aryland /		rtment of H		i Mental Hyg		2005	30	N 7 F
	Physici /Medic		Decedent's Name (First, Middle, Las MARIE	it)		SCH	MIDT		2. Date of Dea Month 09		Year 2005	3. Time of 1 1:25	
	Examin		4a. Facility Name (If not institution, given FOREST HILL HEALT 5. Social Security Number 6. S	H AND REH		irthday)	4b. City, Town, or FOREST			F	LARFORD	Diago (State on	Foreign
	Funeral Director		217-09-7918 Usual Residence of Decedent	□м 21Д г	93	Yrs.	Months Days	Hours M		Year)	Mary		Foreign
	he Marylar 28a-f show	Director	MD Baltimor 10e. Street and Number	е	10c. City, Tov	m or Loc seda.	le					10d. Inside City 1 ☐ Yes	,
	23a or	rai Dir	8222 Dorset Avenu	e			10f. Zip Code 21237			S.A	on of What Cou	ntry?	
036	within 72 hours atter death with the Maryland ene. than 'natural', or Items 23a or 28a-f show he Medical Era ni er maat ke notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 🏋 Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	•	If	Vas Decedent of Hi Yes, specify Cubar ☐ Yes 2√2 No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)		Race - Americ Black, White, Specify: W		
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner manthe notified at	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or	5+)	(Give I life. E	ent's Usual Occupa kind of work done d OO NOT use retired)	uring most of w	vorking		of Business/In Home	dustry	
and	ould be filed v Mental Hygie wrked other t atic event, to	Be	17. Father's Name (First, Middle, Last) Thomas Pasco			IOIICI	IIAKEI		ame (First, Middle, i	Maiden S			
lary	2 should and Men is marke aumatic	To	19a. Informant's Name/Relationship (7		1			nd Number or	.ca Unkno Rural Route Numbel	, City or		Code)	-
	s 1 and f Health Item 27 other tr		Shirley Regester/ 20a. Method of Disposition	daughter	20b. Place o	of Dispos	SCOTTS dall sition (Name of latory or other place		Init L Be		r, MD ation - City or To	21085 own, State	
altimore,	t. Partmer		1 □ Surial 2 □ Cremation 3 □ `4 □ Donation 5 □ Other (Specify)		is of	f Faith	9/1			dale, M		<u>1</u>
Ba	Departing Department of the partment of the pa	1	21. Signature of Funeral Service Licen		~	12	Name and Address 211 Chesa	s of Facility C co Aven	vach/Rose ue Rosed	dale ale 1	Funera MD 212	1 Home 37	
	Physician Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each li	ne.		r the mode of dying	_		est,		Approximate Interval Betwo Onset and De	een
ı	Examiner	_	Sequentially list conditions,	b									
·0,	icate be executed physician and s the burial-transit	i Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or hijbry that initiated events resulting in death) Last	c	a consequence								l l
68760	tificate big physic as the b	l edicai		d									
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)			236	d. Date of delive Month	ory Day Ye	∍ar
Records, P.	w requires that been signed by should be deta		Part II. Other significant conditions of	ontributing to death b	ut not resulting i	in the un	derlying cause give	n in Part I.		acco use	contribute to the	4,	
-		Completed							24a. Was a autops perform 1 ☐ Yes 2	v	24b. Were auto prior to cor death? 1 ☐ Yes	npletion of cau	railable use of
of Vital	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatie	ent 2 ER/Ou	utpatient	3□ DOA Other		eath (Check only on Home 5 Reside		☐Other (Specify	<i>(</i>)	
ion	ktending Ph death. ctor: Atter th y the funeral	ation;	27. Manner of Death Natural 5 Pending 2 Accident investigation		ry Year) 28b.	Time of Injury	28c. Injury Work' M 1 ☐ Y	at ? es 2 ∐No	28d. Describe ho	w injury o	occurred		
Division	al or Attences after death	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, fa c. <i>(Specify)</i>	arm, stre	et, factory, office		28f. Location (Sti City or Town	eet and f , State)	Number or Rura	l Route Numbe	∍r,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edical (29a. Certifier (Check only one) Check only one)	ysician: To the best iner: On the basis of and manner sta	t examination an	e, death	occurred at the time estigation, in my opi	e, date and place inion, death occ	ce, and due to the ca curred at the time, da	use(s) ar ite and pl	nd manner as st ace, and due to	ated. the cause(s)	
	To the Comp	Σ	29b. Signature and title of certifier	÷			29c. License				signed (Month, I		
h	9		30. Name and address of person who o				rint)	2275		e po	-12,2	WAS	
7	Sta	te	DR. DAVID DUNN 31. Date filed (Month, Day, Year) SEP 1 5	32. Regi	Signature		OAD, BEL	AIR, MI	21014				
	Registr	ar	SEP 1 5	2005	egua l	K A	parte						

DHMH 17 Rev 1/2001

			For Stete Registrer	State of I	Marylan		artment <i>rtificate</i>			and M	lental Hy	giene Reg. No.	005	3007
	hysicia		Decedent's Name (First, Middle Ernst	Szillat							2. Date of De Month	Day	Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution,		er)		4b. City, T	Town, or	Location of	of Death	Septe		inty of Death	5 7:50 p. [™]
	- Admini	CI	9312 Ravenrio	lge Road			Pa	rkv:	ille			E	Baltim	ore Co.
	ineral rector		5. Social Security Number 217-38-7873	6. Sex 7. 1 X M 2 □ F	Age (In yrs. 87	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Jan. 3	th 1 <i>y, Year)</i> 1,1918	9. Birth Cou Lit	place (State or Foreign ntry) huania
pug	3		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation		-					10d. Inside City Limits
5-0036 72 hours after death with the Maryland	id other then "naturel", or itams 23a or 28a-f show event, the Medical Exertiret must be notified at	10		imore Co.			 <ville< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>1 ☐ Yes 💥 ☐ No</td></ville<>							1 ☐ Yes 💥 ☐ No
the	r 28a	rect	10e. Street and Number	711101 6 00.		Γαιι	10f. Zip (10g. Citizen	of What Cou	ntry?
th with	23a o	Funeral Director	9312 Raver	ridge Roa	d			212	234			Unit	ed Sta	ates
ar dea	tams	uner	11. Marital Status	12. Was Decede Armed Force	s?	.S. 13.	Was Decede	ent of Hi	spanic Ori	gin? (Spe , Puerto	cify Yes or No Rican, etc.))- 14. F	Race - Ameri Black, White,	
36 rs afte	r, or	by Fi	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 □ Yes 2 If Yes, Give Year or Date			1 ☐ Yes 2	X No	Specify:					ite
2 hou	ature	ted	15. Decedent	s Education		16a. Dece	dent's Usual	Occupa	ition			16b. Kind of	f Business/In	
within 7	Media Media	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4	or 5+)		dent's Usual kind of work DO NOT use			of worki	ng			
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and I be fi	ked of	Be	17. Father's Name (First, Middle, I	.ast)							(First, Middle	, Maiden Sum	name)	
aryla shoutd nd Men	mark	ို	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	na Address	(Street a		nkno or Bura	NTI I Route Numb	er City or Toy	wn State Zir	Code)
	27 ls r trau			lemain/Dau	ahter	1	2 Rave				Baltim			
D - I	item othe		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name	e of her place	9)		ate		on - City or To	
Baltimore,	ortent: If item 27 is marke injury or other traumatic e.		1 X Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (Sp	ecify)	Gan	rdens d			1	9/17	/2005	Balti	more,	Maryland
Baltimo permit. Pages Department of	import eny inj once.		21. Signature of Funeral Service I	Michael	E. Cana		. Name and					5305 Ha		
م م م	= 0 O		OZa Barti Estar the disease and	7/			Leonar					Baltimo	ore, M	
100	*		23a. Part1. Enter the disease, of shock, or heart failure. List of Immediate Cause (Final	only one cause on eac	h line.			or ayıng	, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
Pnys /Me	dician dical		disease or condition resulting in death)	a	HYP	uence of):	ia							24 HOUNG
Exar	niner			Due 10 (01	1000	1005+	IVE	He	art	Fal	lune			INUL
. / 3	=	ner	Sequentially list conditions, Tank Scaling to minuscrate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or	as a conseq	usine offy				-	lune			
/60, ke be executed	nysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to fee	COXC as a conseq	worky	19.	xte	Ry	DI	158451	<i>P</i>		204.00
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. Box 68 death certifica	ad by the attending ph detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	me of pregna		Ectopic pre	ananav				23d. I	Date of delive	ery
o deat	he att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		t at time of d		Other (spe					1	Month	Day Year
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ds,	8.8		Fait II. Other significant conditio	ns contributing to deat	II DULIIOLI 195	uitiiig si tri o ui	ndenying ca	use give	n in Part I.		230. Did (pably 4 Unknown
Records, he taw requires t	shoul	letec									24a. Was			
ا الله الله الله الله الله الله الله ال	has Je 2	Completed									auto	osy rmed?	prior to co death?	psy findings available mpletion of cause of
	certificata rector, pag	0	25. Was case referred to medical			-			26. Place	of Death	(Check only of	25 No	1 ∐ Yes	2 No
of Vita	direc	ToB	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inp.	atient 2	ER/Outpatien	t 3 DOA	Othe			ne 5 Resi		Other (Specif	iy)
	r: After this o e funeral din		27. Manner of Death 1 Natural 5 Pending 2 Accident Investig		njury Day Year)	28b. Time of Injury	28 M	c. Injury Work	at	2	8d. Describe	now injury occ	urred	
DIVISION I or Attending after death.	Directo I in by th	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 28e. Place of	Injury - At ho etc. (Specify	ome, farm, str	eet, factory,	office		2	8f. Location (. City or Tox	Street and Nui vn, State)	mber or Rura	I Route Number,
DIVISIO To the Hospitel or Attendi within 24 hours after death.	To the Funerel Director: completely filled in by the	edicai C	29a. Certifier 1 Certifying (Check only one)	Physician: To the basis xaminer: On the basis	s of examina	wledge, death tion and/or inv	occurred a	t the time	e, date and inion, deat	d place, a h occurre	ind due to the ed at the time,	cause(s) and a	manner as s e, and due to	tated. the cause(s)
ro the	omple	Me	29b. Signature and title of certifier						number			29d. Date sign		
			1 /oh 20	Rucit	MO		D	003	5041	4		9/14	1/200	5
/	0		30. Name and address of person v	vho completed cause of	of death (Item	1 23а) (Туре,	Print)		, 2		lle,		1	_
	e		JOHN ANCOT	T, MD	10755	Fall	S RD	1	un	LXV1	1/4 ,	ND C	1109	3
	Sta Registra		31. Date filed (Month, Day, Year) SEP 1 5		strar's Signa	ture	4.							
DHMH 17	``	-	SEP 1 5	2005	en ,	I A								
				1.70		ORIGINA	\L							

		1	For State Registrar	State of Maryland		irtment of I tificate of			giene Reg. No. 20	05 30078
4	Physici /Medic	an	Decedent's Name (First, Middle, Last) I RENE		S	ACHS		2. Date of De Month	Day	Year 2005 2745 AM
2	Examin	er	4a. Facility Name (If not institution, give s Sina: Hospita 5. Social Security Number 6. Sex	al	st birthday)	D		h Data of Ric	4c. County	of Death N/A 9. Birthplace (State or Foreign
	Funeral Director			² M ² X F 97	Yrs.	Months Days	Hours Min.	JUNE 1	8,1908	MD MD
	n the Maryli r 28a-f eho	Director		IMORE	BALT	I MORE			10g. Citizen of V	1 ☐ Yes 2 🙀 No
036	d within 72 hours atter death with the Maryland Jone. I then "natural", or items 23a or 28a-f ehow The Macical Examiner must be mullied at	by Funeral	2331 OLD COURT R 11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	OAD #210 12. Was Decedent Ever in U.S Armed Forces? 1		Nas Decedent of 1 Yes, specify Cut	21208 Hispanic Origin? (Specify:	Specify Yes or No to Rican, etc.)		USA e - American Indian, ck, White, etc. WHITE
21215-0036	s within jene.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12		(Give	lent's Usual Occu kind of work done DO NOT use retire	iduring most of wo		OWN HOM	
Maryland	d ta D	To Be	17. Father's Name (First, Middle, Last) WILLIAM		FOGE	L	18. Mother's Na	me (First, Middle	, Maiden Sumarr	(UNKNOWN)
	s 1 end 2 should f Health and Mer item 27 is marks other traumatic		19a. Informant's Name/Relationship (Ty WILMA SCHUSTER /	,		-	t and Number or R RSE LANE			State, Zip Code) RE, MD 21208
Baltimore,			20a. Method of Disposition 1	Removal from State CO	metery, crer	sition (Name of natory or other pla HEBREW	CEM. 09/	Date 13/2005		City or Town, State
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	99						ROS., INC. LE, MD 21208
	Physician		23a. Part1. Priter the disease, or compleshoot, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death, ne cause on each line.		er the mode of dy		c or respiratory a	rrest,	Approximate Interval Between Onset and Death 2 Years
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.O. Box 6	death certifi e ettending d for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. ff yes, outcome of pregnar 1 Live birth 2 Fetel 4 Pregnant at time of de 9 Unknown	death 3[Ectopic pregnant	су		23d. Da	te of delivery nnth Day Year
<u>α</u>	signed be de	by	Part If. Other significant conditions co	ntributing to death but not resu	lting in the u	ndertying cause g	iven in Part I.		obacco use cont Yes 2 □ No	nbute to the cause of death? 3 Probably 4 Monknown
Il Records,		Completed						24a. Was auto perfo 1 Yes	psy ormed?	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Division of Vital	Attending Physician: Thir death. ector: After this certificate by the funeral director, peg	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o fnjury	28c. Inju	ther: 4 Nursing only at ork? Yes 2 No		dence 6 Oth	red
Div	To the Hospital or Attent within 24 hours efter death To the Funeral Director: completely filled in by the		4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify, sician: To the best of my know)			City or To	wn, State)	per or Rural Route Number,
	the Hosithin 24 h	Medical	(Check only one) 2 Medical Exami	iner: On the basis of examinati and manner stated.	ion and/or in	vestigation, in my	opinion, death occ	urred at the time,	date and place,	and due to the cause(s) d (Month, Day, Year)
	+ 3 - 5		1	, 50		RE	5 00	2		ber 10, 2005
-	15		30. Name and address of person who co	2401 West	- Bel	Print)	Ave Be	eltimos.	e MD	21215
1	St Regist	ate rar	31. Date filed (Month, Day, Year) SFP 1 5	32. Redistrar's Signat	dr.	hall			•	

		1	For State of I	Maryland / Dep <i>Ce</i>	ertificate of l			iene 2005	30079
			1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	n Day Year	3. Time of Death
	Physicia /Medic	al .	Valerie Helen Schmidbaue				09-08-		5:30 A ^M
	Examin	er	ta. Facility Name (If not institution, give street and numb	er)		Location of Death	1	4c. County of Deat	h
			879 W. Lombard St. 5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday	Baltimor	If Under 24 Hrs.	8. Date of Birth	9. Birti	nplace (State or Foreign
- 6	Funeral Director		215-01-0687	85 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 07-17-19	920 Balt	cimore, MD
	σ		Usual Residence of Decedent	10c. City, Town or L					10d. Inside City Limits
	show	5	10a. State 10b. County						1 ☐ Yes 2 ☐ No
	the N 28a-f	recto	MD 10e, Street and Number	Baltimo	10f. Zip Code		10	og. Citizen of What Co	untry?
	3a or		879 W. Lombard St.		21201			USA	
	death	ner	11. Marital Status 12. Was Decede Armed Force	ent Ever in U.S. 13	. Was Decedent of H	ispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
36	flied within 72 hours after death with the Maryland Hygiene. Hygiene. the Whysica than "natural", or Itams 23a or 28a-f show ant, It & Mazical Examiner must be notified at ant.	Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2	No X	1 ☐ Yes 2 ☑ No	Specify:		Specify W hit	
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no	ding After fune	tlon	1 Natural 5 Pending (Month,	Day Year) 200. Time Injury	Wor	yat k? Yes 2 ⊡No	28d. Describe 110	w injury occurred	
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	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner and manner.	is of examination and/or					
)	To the within To the Comp	W	296- Signatore and title of certifier		29c. Licens	6 number		9d. Date signed (Monti	h, Day, Year)
	1		30. Name and address of person who completed cause Rizal A. Wing row MI		e, Print)	aud P	bry mor	i find	21223
	Sta Regist		31. Date filed (Month, Day, Year) SEP 1 5 2005	gistrar's Signature	hiere				

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State of Maryland / Department of Health and Mental Hygiene 21. State Unpend Item 23a, pt.II, 27 per me chilicate of Death 23a, pt.II, 27 per me chilicate of Death 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 **Physician** SEPT. 8 James E. Tilghman 0946 A M /Medical 4a. Facility Name (If not institution, give street and number)
8890 STANFORD BOULEVARD 4c. County of Death HOWARD 4b. City, Town, or Location of Death COLUMBIA Examiner If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/20/1963 Birthplace (State or Foreign Country) **Funeral** 1**X**□XM 2□ F 41 Yrs Director 212-84-4199 PA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ehow r than "natural", or itema 23a or 28a-f ehov the Medical Examiner must be notified at Wicomico 1 Yes 2 □ No MDQuantico Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25382 Fairway Drive 21856 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 💢 🌠 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐XNo Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Alarm Installer Security permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any Injury or other traumatic event 9DRB. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald Matthews Tilghman Mary Elizabeth Schisster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lori Ann Tilghman (sister) 14019 Salten Court Midlothian, VA 22113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 9/19/2005 1 ☐ Burial TCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Chesapeake Crematory 22. Name and Address of Facility Witzke Funeral Homes, 21. Signature of Funeral Service Licensee 5555 Twin Knolls Rd. Columbia, 23a. Part 1. Enter the lifease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Hypertensive Heart Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a nonsequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes Mellitus; End Stage Renal Disease 3 Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No been si 24a. Was an 24b. Were autopsy findings available prior to completion of cause of day h?

1 X Yes 2 □ No certificate has b irector, page 2 s 1 Yes 2 🗆 No director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 MOther (Specify) AT SCENE မ 1 X Yes 2 ☐ No this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury After 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft to the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) SEPT. 9, 2005 29b. Signature and title of certifier 29c. License number O.C.M.E se of death (Item 23a) (Type, Print) Pollak 111 PENN STREET, BALTIMORE, MARYLAND 21201 32. Phoistrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2005

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	Plea				d / Dep	artme	nt of H		and M	l Copie lental H	ygien	e ₂ nn	le.) 5	30081
	Physici /Medic		1. Decedent's Na	me (First, Middl Raymond		Van K	irk S		111100	10 01			2. Date of D Month SEP T		ay Y	ear	3. Time of Death
	Examin		4a. Facility Name Univer	(If not institution sity of	-			al		, Town, o altin	r Location on the core	of Death		4	c. County of	Death	
	Funeral Director		5. Social Security 213–54–	4788	6. Sex 1 X M	7. / 2 🗆 F	Age (In yrs. 55	last birthday Yrs.	Months	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, L May 11	Dav. Yea	7)	Counti	nce (State or Foreign y) Ore, MD
	e maryland 3e-f show ilified at	Director	Usual Residence 10a. State MD	10b. County	/A		10c. Cit	y, Town or L Balti								10	d. Inside City Limits 1 Yes 2 □ No
2	atn with it	ral Dire	10e. Street and N	Jack P1						ip Code 2122					itizen of Wh USA		
0500-6	Z should be lied within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "netural", or Items 23e or 28e-f show aumatic event, It's Madical Examinations to inclined a	by Funeral	_	rried 2∏ Mar 4 (★Divorced	ried 1	as Deceder med Force: Yes 20 Yes, Give (ear or Dates	s? No	.S. 13.	Was Dec If Yes, sp	-	lispanic Ori an, Mexicar Specify:		ecify Yes or N Rican, etc.)	lo-		America White, et Whit	tc.
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₹ :	D = N =		19a. Informant's Kimberly			rint)		2019	Shore	e Road	and Number I, Dunda		I Route Num 21222	ber, City	or Town, St	ate, Zip C	Code)
Saltimore	perrit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.			isposition 2 ≸ Cremation 1 5 □ Other (S		al from Stat		Place of Disp emetery, cre View Cr	matory or	other place	ce)	Sept. 2005	9 ,		Location - Ci 1 timore		n, State
משוב	perrit. Depirtri Importe any inji		21. Signature of	uneral Service	Licensee			2	2. Name a Charle 1501	and Addres S L. Fast F	ss of Facilit Steven ort Av	s Fun e Bal	eral Hom timore N	ne In 1021			
	nysician		23a. Part1. Enter shock, or he Immediate Cause disease or condit	e (Final	complication only one cau	ns that caus use on each	A		ter the mo	de of dyin	g, such as	cardiac o					Approximate nterval Between Onset and Death
	/Medical		resulting in death	1)	(a	Due to (or a			MUNH	7	14 00 0	1219				11	MCDIATE
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	uted d ansit	Examiner	cause. Enter Und Cause (Disease of that initiated even	or injury	ζ.	2 43 10 (01 0		RBLO	0 355	iTY						~	12 NONTHS
	ite be executed ysician and ie burial-transit	7	resulting in death		d	Due to (or a				1							PLUS
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ecords, r	w requires that the de been signed by the s should be detached	by	Part II. Other sign		TIC SI									tobacco Yes 2		ite to the ⊒Probab	cause of death?
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Ion of Vital	To the nospitel or Attending Priysician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	ation: To Be	25. Was case referenced a common comm	□ No ath 5 □ Pendir	Hospita 28a	al: 1 Anpa a. Date of In (Month, D	iury	ER/Outpatie 28b. Time of Injury		28c. Injury Work	^{9r:} 4□ Nu ⁄at	rsing Hon	Check online 5 Res	idence		Specify)	25
DIVISION	after des	Certification:	3 Suicide 4 Homicide	6 ☐ Could determ		e. Place of l building,	njury - At ho etc. <i>(Specif</i>)	ome, farm, st	reet, facto	ry, office		2	8f. Location City or To	(Street a wn, Stat	nd Number (e)	or Rural F	Route Number,
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1	21		J. PLYNN	dress of person	WERSIT	ed cause of	death (Item	23a) (Type,	Print)	1. Sou	TH CU	2 1412L	1230 Es s	+ 6	BALTIA	Lors	e Md.
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Registrar

5 2005

SEPTEMBER

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			State (of Maryland / Depa		lealth and N	lental Hygi	•	30083
I	Physicia	an	1. Decedent's Name (First, Middle, Last) John Brown Wallace				2. Date of Death Month		3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution, give street and not Presbyterian Home 400 (5. Social Security Number 6. Sex		4b. City, Town, o Towson If Under 1 Year	r Location of Death		4c. County of Death Baltimore	lace (State or Foreign
	Funeral Director		216-05-2812 1√2 M 2□F Usual Residence of Decedent	93 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1) May 19,		
	the Marylar 28a-f show	ector	Maryland Baltimore 10e. Street and Number	10c. City, Town or Lo			100	g. Citizen of What Coun	0d. Inside City Limits 1y Yes 2 □ No try?
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, if a Medical Eracidist institue notified at once.	by Funeral Director	400 Georgia Court 11. Marital Status 12. Was Dec. Armed F	2 □ No τπτ~~		21204 dispanic Origin? (Span, Mexican, Puerto		USA 14. Race - Americ Black, White, Specify: Whit	an Indian, etc.
Maryland 21215-0036	thin 72 hours a 6. an "natural", d Medical Exer	Completed by	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College) 16a. Dece (Give iife.	dent's Usual Occup kind of work done DO NOT use retired	ation	king	6b. Kind of Business/Ind	dustry
land 21	uld be filed wi Nental Hyglen rked othar th	To Be Con	12 3 17. Father's Name (First, Middle, Last) John Wallace	Chen	nist	_	Tweedie	Chemical Co	mpany
	l and 2 shoule and Nealth and Nealth and New 27 is maintentrauma!		19a. Informant's Name/Relationship (Type, Print) Donald Hoatson Nepho 20a. Method of Disposition	ew 163	304 Falls	Road, Up	perco, Ma	City or Town, State, Ziparyland 211 Oc. Location - City or To	55
Baltimore,	permit. Pages Department of Himportant: If ite any Injury or of any Injury or of once.		15 Burial 2 □ Cremation 3 □ Removal from 14 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Moreland	Memoria1 2. Name and Addre	Park 9/1	5/2005 I	Parkville,	
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one curse on Immediate Cause (Final disease or condition resulting in death)	caused the death. Do not en each line.	3631 Fall ter the mode of dyin	ng, such as cardiac	altimore, or respiratory arres	Home, Inc. Maryland	21211 Approximate Interval Between Onset and Death
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tal Reco	alcian: The law r certificate has be irector, page 2 sh		Fulture ay Fizios 25. Was case referred to medical	<i>(</i>) <i>(</i>		26 Place of Dog	24a. Was an autopsy performe 1 Yes 2	ed? prior to cor death? No 1 □ Yes	osy findings available appletion of cause of
Division of Vital Records,	To the Hospital or Attending Phyalcian: The law requires that the death certificat within 24 hours after death. To the Funeral Diractor: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Certification; To Be	examiner? 1 Yes 2 No Hospital: 1 27. May er of Death 1 Natural 5 Pending investigation 2 Accident investigation	Inpatient 2 ER/Outpatien a of Injury 28b. Time of Injury Injury	of 28c. Injur Wor M 1	ner: 4 - Nursing H	ome 5 Residen 28d. Describe how	oce 6 Other (Specify vinjury occurred	
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,	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Examiner: On the	basis of examination and/or inner stated.	29c. Licens	opinion, death occu	rred at the time, dat	d. Date signed (Month,	the cause(s)
	10X)		30. Name and address of person who completed ca	se of death (Item 23a) (Type,			BATIL	wort M	0 21204
	Sta Registi		31. Date filed (Month, Day, Year) SEP 1 5 2005	Registrar's Signature					,

Rev 1/200

Year

2. Date of Death Month

/Medi	cal	Martha	Anne	e Walters					mber	10 , 2	005 1:07E) 1/1
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		Holy Cross Hosp					r Spri			Montg	omery	
Funeral		5. Social Security Number	6. Sex 1 ☐ M	7. Age (In yi		Months Days		Min. (Month,	Day, Year)	9	Birthplace (State or Country)	Foreigi
Director		579-48-0058		71		rs.		Nov.	13, 1	933 S	outh Carol	ina
and and		Usual Residence of Decedent 10a. State 10b. County		10c.	City, Town	or Location					10d. Inside City	/ Limits
lanyl Feho	5	Maryland Freder	ei ole		Mon	rovia					1 □ Yes 2	2√∑ No
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with	급						^				at Country!	
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iter d	Funerai	11. Marital Status 1 □ Never Married 2 □ Marri	A	med Forces? ☐Yes 2⊠No	0.0.	If Yes, specify Cu	ban, Mexican	, Puerto Rican, etc.)	110-		White, etc.	
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other treumatic event, the Mexical Examinar must be rotilled at	d by F	3 ☐ Widowed 4 🎇 Divorced	l If	Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:			Specify:	White	
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d 2 should be filed within ' h and Mental Hygiene. 7 is marked other than " treumatic event, the Me	E	Elementary/Secondary (0-12)	"	College (1-4or 5+)		ninistrativ			Pı	rivate	Industry	
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d be Botal Ked c	To Be	James F. Ma	rtin					Reba V	ickery	: 7		
maria M	F	19a. Informant's Name/Relationsh		Print)	19b. I	Mailing Address (Stree	t and Numbe		-		ate. Zip Code)	
ith ar 27 is 17 is		Stephanie A. Sm	ith -	Daughter	110	003 Wonder	Court	Monrovi	n Man	cul and	1 21770	
Department of Health a Importent: If Item 27 is any injury or other tree		20a. Method of Disposition		20b	. Place of D	Disposition (Name of		Date		-	ty or Town, State	
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tend or us	an/	23b. Was decedent pregnant in the past 12 months?	1	yes, outcome of preg	tal death	3 □Ectopic pregnanc	у		101	23d. Date o Month		121
he el he d'fc	Sici	1 ☐ Yes 2 🖾 No		□Pregnant at time of □Unknown	f death	5 Other (specify)			-	WOITH	Day 16	a.
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should should								1	☐Yes 2	□No 3[Probably 4x Uni	known
ate has been signed by the ettending physician end bage 2 should be detached for use as the burial-transit	piet							24a. W		24b. Wer	e autopsy findings av	allable
te has age 2	Completed							pe	itopsy informed? s 2 \(\sigma\) No	dea	r to completion of cau th? Yes 2█ No	36 01
certificate ha rector, page	a	25. Was case referred to medical					26. Place	of Death (Check on			103 22110	
is cer direct	To B	examiner? 1 ☐ Yes 2 ☐XNo	Hospit	al: 1 XInpatient 2	☐ ER/Outp	atient 3 DOA Ot	har	rsing Home 5 ☐ Ri		6 Other ((Specify)	
두평		27. Manner of Death	28	a. Date of Injury	28b. Tin	ne of 28c. Inju	ry at	28d. Descrit			Specify)	
th. : After th funeral	ţ	1 XNatural 5 ☐ Pending 2 ☐ Accident investig.		(Month, Day Year)	Inju		nrk?]Yes 2∐N	No				
after death. I Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could n		e. Place of Injury - At	home, farm	, street, factory, office					or Rural Route Numbe	er,
arter Dire J in t	erti	4 Homicide	100	building, etc. (Spe	cify)			City or	Town, State)		
within 24 hours at To the Funeral D completely filled in		29a. Certifier 1 🔀 Certifying	2 Physiciar	: To the best of my k	nowledge.	death occurred at the t	me, date and	place, and due to t	ne cause(s)	and manne	er as stated.	
Fur etely	edical	(Check only 2 Medical E	Examiner: (On the basis of examined manner stated.	nation and/	or investigation, in my	opinion, deat	h occurred at the tim	e, date and	place, and	due to the cause(s)	
0 th	Me	29b. Signature and title of certifier				29c. Licen	se number		29d. Dat	e signed (N	fonth, Day, Year)	
s⊢ ö			Cor	nnie Le,	M.D.	D60	619		Sep	t. 12	, 2005	
/		on None							- 1			
15		30. Name and address of person v		·								
1 - 0		1500 Forest G	len R	load, Silv 32. Pegistrar's Sig	zer Sp	oring, Mary	yland	20910				
Sta Registr			2005			A 4.						
	The second of th											
MH 17 Rev 1/2	001			-								

DOD: 9/9/05 \$ TOD: 1:50 PM Baltimore, Maryland 21215-0036 Hnown to physicano aci Melun With

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 5

30085

Physician /Medical Examiner 4a. Facility Name (If not institution, give street and number) Homewood at Crumlands Farm Funeral Director 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 80 Yrs. Welvin L. Whitefield Sex 4b. City, Town, or Location of Death Frederick Funeral 220-16-6149 Usual Residence of Decedent	ate of Death Month ptember	Day Year	3. Time of Death 1:50 PM M
Medical Examiner 4a. Facility Name (If not institution, give street and number) Homewood at Crumlands Farm Funeral Director 5. Social Security Number 6. Sex 1/2 M 2□F 80 Yrs. 120-16-6149 Usual Residence of Decedent	ate of Rinth	1	1:50 PM M
Homewood at Crumlands Farm Frederick Funeral Director $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	ate of Birth	4c. County of Dea	
Funeral Director 5. Social Security Number 6. Sex 1 7. Age (In yrs. last birthday) 1 1 Under 1 Year If Under 24 Hrs. 8. D Amonths Days Hours Min. Oc (A Oc	ate of Birth	Fee a 4	
Director Usual Residence of Decedent		Freder	thplace /State or Foreign
10a. State 10b. County 10c. City, Town or Location	t 4, 1	Year) C	yland
			10d. Inside City Limits
MD Frederick Frederick			1 ☐ Yes 2√ No
E TOE. Street and Number 10f. Zip Code	10	g. Citizen of What C	ountry?
MD Frederick Frederick 10e. Street and Number 7401 Willow Road #250 11. Marital Status 1 Never Married 2 Married		USA	
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rican II) Was Signature of the Specify Cuban, Mexican, Puerto Rican II) Was Signature of the Specify Cuban, Mexican Puerto Rican II) Was Signature of the Specify Cuban, Mexican Puerto Rican II) Was Specify Cuban, Mexican Puerto Rican III) Was Specify Cuban, Mexican Puerto Rican III) Was Signature of the Specify Cuban Puerto Rican III) Was Specify Cuban, Mexican III Was Specify Cuban, Mexican	res or No- i, etc.)	14. Race - Am Black, Whi	
If Yes, Give 1 □ Yes 2 No Specify:		Specify: wh	nite
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) 12 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) 12 15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17. Sales manager	16	6b. Kind of Business	/Industry
(Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired)		1.6	
12 5+ sales manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First	t. Middle. Ma	self emp	loyed
17. Father's Name (First), Middle, Last) Roy Whitefield Roy Whitefield Mildred Father's Name (First), Middle, Last)			
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Rou	te Number, (City or Town, State,	Zip Code)
Mary Lou Whitefield/spouse 7401 Willow Road #250 Fre	ederic	k, MD 21	702
20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 1 □ Burial 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place)	20	Oc. Location - City or	Town, State
21. Signature Leuneral Service Licensee Pirector State Anatomy Board 65	5 W. I	Baltimore	Street
Baltimore, MD 21201 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resp	piratory arres	+	Approximate
shock or heart failure. List only one cause on each line.	,	,	Interval Between Onset and Death
/Medical disease or condition resulting in death) Due to (or as a consequence of):			
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to similarity that initiated events resulting in death) Sequentially list conditions, if any, leading to similarity that initiated events resulting in death) Log to (or as a consequence of): Due to (or as a consequence of): AUS CLUCY Due to (or as a consequence of): Log to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Log to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): AUS CLUCY Due to (or as a consequence of): Due to (or as a consequence of): AUS CLUCY Due to (or as a consequence of): Due to (or as a consequence of): AUS CLUCY Due to (or as a consequence of): AUS CLUCY Due to (or as a consequence of): AUS CLUCY Due to (or as a consequence of): AUS CLUCY AUS CLUCY Due to (or as a consequence of): AUS CLUCY Due to (or as a consequence of): AUS CLUCY AUS CLUCY DUE to (or as a consequence of): AUS CLUCY AUS CLUCY DUE to (or as a consequence of): AUS CLUCY AUS CLUCY DUE to (or as a consequence of): AUS CLUCY AUS CLUCY DUE to (or as a consequence of): AUS CLUCY AUS CLUCY DUE to (or as a consequence of): AUS CLUCY AUS CLUCY DUE to (or as a consequence of): AUS CLUCY AUS CLUCY AUS CLUCY DUE to (or as a consequence of): AUS CLUCY AUS CLUCY AUS CLUCY DUE to (or as a consequence of): AUS CLUCY	Seas	e	54RS.
Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury)			· ·
De De Lause. Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
The control of the co			
Medical by a stiff of the partition of t			
For Signature State Sta		23d. Date of del	-
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 23c. If yes, outcome of pregnancy 5 Other (specify) 9 Unknown 23c. If yes, outcome of pregnancy 5 Other (specify) 9 Unknown 5 Other (specify) 9 Unknown 5 Other (specify) 5 Other (specify		Month	Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	3e. Did toba	cco use contribute to	the cause of death?
S S S S S S S S S S S S S S S S S S S	1 ☐ Yes		obably 4 Unknown
Una Gotomountes fund blead	4a. Was an	24b. Were at	topsy findings available
The law require the stand of the condition of the stand o	autopsy performe	d? prior to death?	completion of cause of
5 0 25. Was case referred to medical 26. Place of Death (Che		No 1 □ Yes	2 No
examiner? Solid S	Residenc	ce 6 □Other (Spec	cify)
28d. Date of Injury 28b. Time of 28c. Injury at 28d. D	escribe how	injury occurred	
2 Accident investigation M 1 Yes 2 No 2 Still Suicide 6 Could night be 28e. Place of Injury - At home, farm, street, factory, office 28f. Lo	nation /Strac	et and Number or Ru	um l Douto Number
28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Date of Injury 28b. Time of 28c. Injury at Work?	ity or Town, S	State)	rai noble Number,
23c. If yes, outcome of pregnancy 1	e to the caus he time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
29b. Signature and title of certifier 29c. License number	29d.	. Date signed (Month	n, Day, Year)
Joseph Hollwal My DZ6609	9	-9-05	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	חרשת	1	
State Step 1 5 2005 State SEP 1 5 2005 State State Step 1 5 2005	2170	l	4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4
Registrar SEP 1 5 2005 Been 15 April			

State of Maryland / Department of Health and Mental Hygiene 2005

		Certificate of Death	Reg. No.	5 30086
Physician	Decedent's Name (First, Middle, Last)		2. Date of Deeth Month Day Yes	3. Time of Death
/Medical	Anna Zornes	At Ch. Town and	September 5,2005	3:00pm
Examiner	4e Fecility Neme (If not institution, give street end number) Quail Assisted Living	4b. City, Town, or L Baltim		
	5. Social Security Number 6. Sex 7. Age (In yrs. lest by			
Funeral Director	287-14-3886 1□ M 2 ★ 81 Usuel Residence of Decedent	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Dey, Year) May 20,1924	Birthplace (Stete or Foreigr Country) incinnati, CH
art show	10a. Stete 10b. County 10c. City, Tot	wn or Location ry Hall		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
r items 23s or 28s-fs niner must be notified Funeral Director	10e. Street end Number 9900 Walther Blvd.	10f. Zip Code 21234	10g. Citizen of Whet USA	Country?
"natural", or frams 23a or 28a-f show selical Examinar must be notified at leted by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spirif Yes, specify Cuban, Mexican, Puerto		
	15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 12	e. Decedent's Usuel Occupation (Give kind of work done during most of work life. Do NOT use retired) ACCOUNTANT	office	ss/industry
Mentel Hygiene. arked other than atic event, the M To Be Comp	17. Fether's Neme (First, Middle, Last) Mariano Beccaccio	18. Mother's Nam ROSE	e (First, Middle, Maiden Surname) Palma	
th end 7 is m treum	19a. Informant's Name/Relationship (Type, Print) John Zorns / Son	b. Mailing Address (Street and Number or Rui 331 Floral Drive Yo	rel Route Number, City or Town, State rk, PA 17402	e, Zip Code)
× = 0	cemet	of Disposition (Name of eny, crematory or other place) seph. Cemetery	Date 20c. Location - City Cincinnati	
Depertment of important: If any injury or once.	21. Signature of Funeral Service Licensee	22. Name end Address of Fecility Charles L. Stevens Fund 1501 Fast Fort Ave Balt	eral Home Inc. cimore MD 21230	
attending physicien and local reason for use as the buriel-trensit claryMedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse, Disease or Injury	a consequence of): E	EASĪ	Onset and Death
by the tached	Pert II. Other significant conditions contributing to deeth but not resulting	in the underlying cause given in Part I.	23b. Did tobacco use contribu	ute to the cause of death?
has been sign ge 2 should be mpleted by			24a. Wes en autopsy performed?	b. Were autopsy findings available prior to completion of cause of death?
.≝ o •	25. Was case referred to medical	26. Place of Deal	h (Check only one)	
<u>∞</u> 0 0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/C	Other:	ome 5 Residence 6 ther (S	pecify) Assited
	1 Maturel 5 ☐ Pending (Month, Dey Year) 2 Accident investigation	Time of Injury at Work? M 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred	Civir
	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street and Number or City or Town, State)	Rural Route Number,
Funer Funer tely fill	29a. Certifier (Check only one) 1	nd/or investigation, in my opinion, death occur	red at the time, date end place, and o	due to the cause(s)
To the comple	29b. Signature and title of certifier SQUINDAY RESULTED IN M.	29c. License number 27/89	29d. Date signed (Mo	onth, Day, Yeer)
T	30 Name and address of person who completed cause of death (Item 23e)	(Type, Print) Place D	Walor MA	21222
State Registrar	31. Dete filed (Month, Day, Year) 32. Registrer's Signature SEP 1 5 2005	* Spirite	and alt	

			1 - For State Registrar	State of Ma		artment of Heartificate of De			2005	30087
	Physici		1. Decedent's Name (First, Middle, La WILLIAM ANDER	_			C	2. Date of Death Month	Day Year	3. Time of Death 9:07 PM
	/Medio		4a. Facility Name (If not institution, giv		·····	4b. City, Town, or Loc BALTIMOR		7111	4c. County of Deat	h
	Funeral		Social Security Number 6. 5	ex 7. Age	(In yrs. last birthday)	If Under 1 Year If	Under 24 Hrs.	8. Date of Birth (Month, Day, Y	(ear) 9. Birt	hplace (State or Foreign
5	Director		Usual Residence of Decedent	4 2 F 6				10.29.10	(4)	MD
death with the Maryland	r 28a-f ehow	to	MD 10b. County		BALTIMO					10d. Inside City Limits 1 Yes 2 No
with the	a or 28s	Director	10e. Street and Number	Danie		10f. Zip Code 21207	7	10g	. Citizen of What Co	untry?
teab	or items 23s or	Funeral	6715 CHISHOLM 11. Marital Status	DRIVE 12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, N		cify Yes or No-	14. Race - Ame Black, White	
OU35	al', or it	Ď	1 ☐ Never Married 2 ⊠ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates:	0		Specify:			-ACK
3 0	7 E S	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give	dent's Usual Occupation kind of work done during DO NOT use retired)	n ng most of workin	g 16	b. Kind of Business/	Industry
	lygiene.		Elementary/Secondary (0-12) 10 TH GRADE	College (1-4or 5+	mati	RESS MAK		(First, Middle, Ma	EDDING (COMPANY
	d ta b	To Be	17. Father's Name (First, Middle, Last OLIVER ANDERSO				LLARA B		iden Sumame)	
Mar	27 ls		19a. Informant's Name/Relationship (1		ng Address (Street and CHISHOLM			•	
ore,	nent of Hea nnt: If item:		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)	Da	ate 20	c. Location - City or	
	Department Department Importent: If any injury or once.		* 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice		WOODLAV	UN 2. Name and Address of AUGHN C · G	09. IS		ALTO, MD	
ñ			23a. Part1. Enter the disease, or com	polications that caused t	5	PL RHID ME	ATC PIKE	RAMO.	IVID ZIZZ	Approximate
	nysician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Necro	9.	fasei stit	95	respiratory arrest	1	Interval Between Onset and Death
	xaminer			Due to (or as a	consequent e of):	Myorce	dent	Marketon and the second		nowthe
for	dansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	- Due to for as a	remsequence of.				-1	~~~
8760,	the burial-transit	<u>.e</u>	resulting in death) Last	Due to (or as a	consequence of):					
/89	ng phys	음	IF FEMALE:	_ d,						
O. Box 68/60,	the ettending pl	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at the second of	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
ords, P.O	been signed by the s should be detached	by	Part II. Other significant conditions	contributing to death but	t not resulting in the u	inderlying cause given in	n Part I.		cco use contribute to	
Hecords,	s peen s	ompieted						24a. Was an	24b. Were au	obably 4 Unknown topsy findings available
	ate h	Com						autopsy performe 1 Yes 2	d2 death?	completion of cause of 2□ No
of Vital	vis certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatien	t 2 ER/Outpatie	Other	 Place of Death Nursing Hom 		ce 6 □Other (Spec	cify)
on of	After this of funeral dir		27. Manner of Death 1/☐Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time o	Work?	2 □ No	8d. Describe how	injury occurred	
DIVISION	after death Director: in by the	Certification:	3 Suicide 6 Could not be determined	e Zoe Blace of Injur	ry - At home, farm, st (Specify)			Bf. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
- leticoot	within 24 hours after death. To the Funeral Director: After completely filled in by the fune	-ca	(Check only 2 Medical Exe	nysician: To the best of niner: On the basis of	examination and/or in	h occurred at the time, ovestigation, in my opinio	date and place, ar	nd due to the caus	se(s) and manner as	stated. to the cause(s)
Tother	within 2 To the complet	Medic	one) 29b. Signature and title of certifier	and manner stat	ed.	29c. License nu	umber	29d	. Date signed (Mont)	h, Day, Year)
	~		▶ Cfreht	a MI)	ath (lane on)	1) 30	4974	S_{-}	OPF 12	2005
1	t '		30. Name and address of person who	AMO61	1 / South	charlos	stree	t, Ral-	A more 1	172/230
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 6 200	72. Registra	's Signature	de!				

			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment rtificate			Mental Hy	giene	005	30088
	Physici /Medi	cal	1. Decedent's Name (First, Middle, La Kathryn Jefferson	Asher	1	T # 02 T			2. Date of D Month Sept.	1 1	2005	3. Time of Death 1:00pm M
	Examir	ner	4a. Fecility Name (If not institution, given 200 South Washing 5. Social Security Number 6. S	ton Stree		Haure If Under 1	de G	Under 24 H		Ho	County of Death Wifiord 9. Birth	place (State or Foreign
	Director		217-01-8155 Usual Residence of Decedent 10a. State 10b. County	□M 2(Z)F	86 Yrs.		Days F	Hours Mi	8. Date of B (Month, D 12/28)	1918	Mary	Land 10d. Inside City Limits
	the Maryli r 28a-f eho	rector	MD Harford 10e. Street and Number		Havre de		ode			10g. Citiz	en of What Cou	1X Yes 2 □ No
9	nit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland artment of Health and Mental Hyglene. ortant: if item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, its Mudical Eventhiar must be notified at a.	Funeral Director	200 South Washing 11. Marital Status 1. Never Married 2 Married	12. Was Decedent Armed Forces 1 \(\text{Yes} \) 2 \(\text{Y}	Ever in U.S. 13.		nt of Hispa Cuban, N		Specify Yes or N into Rican, etc.)	USA o- 1	4. Race - Ameri Black, White	can Indian,
Maryland 21215-0036	hin 72 hours b. In "naturel", Medical Eva	Completed by	3 Widowed 4 Divorced 15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Co kind of work of DO NOT use	Occupation	Specify: n ng most of w	orking		d of Business/Ir	ite ndustry
and 21,	ould be filed within Mental Hygiene. arked other than " atic event, the Ma	Be	17. Father's Name (First, Middle, Last) Arthur P.G. Asher	2 years	Se	elf-Emp	18	. Mother's Na	ame (First, Middle			Company
	and 2 should lealth and Men m 27 is marks her traumatic	To	19a. Informant's Name/Relationship (Donna Mae Asher-				Street and		Rural Route Numb , Havre			
3altimore,	Pages 1 a ment of Hea ent: if item ury or othe		20a. Method of Disposition 1 ⊠ Buriel 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specification)	Removel from State	20b. Place of Disponentery, cre Grove Pre	osition (Name matory or other S. Cemi	ot er place) eterij	1 09/1	Dete 5 / 2005	20c. Loca Aberd	ation - City or To	own, State
Balt	permit. Page Department of Important: if any injury or		21. Signature of Funeral Service Licer 23a. Part1. Enter the disease, or com	. Smil	12	3 S. W	ashi	ngton,	eral Hon Havre o	le Gra	A. ice, MD	
>	Physician /Medical		shock, or heart failure. List only timediate Cause (Final disease or condition resulting in death)	a. Metro	ine. A consequence of:	6 C	holce	W cardia	c or respiratory a	irrest,		Approximate Interval Between Onset and Death
8760,	cate be executed by sicien and the burial-transit and	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):							
O. Box 6	The law requires that the death certificate be executed the hes been signed by the attending physicien and age 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	Ectopic pregr Other (special				23	d. Date of delive	ery Day Year
ords, P.	w requires that been signed b should be deta	ρ	Part II. Other significant conditions of	ontributing to death b	out not resulting in the u	nderlying caus	se given in	Part I.			ocontribute to the	ne cause of death?
of Vital Records,		e Completed	25. Was case referred to medical				26	Place of Do	24a. Was autor perfor 1 Yes ath (Check only)	osy rmed?/ 2 No	prior to con death?	psy findings available impletion of cause of
Ţ.	d o	To B	examine/? 1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ER/Outpatier	it 3 DOA	Other	Nursing I			Other (Specify	<i>'</i>)
Division o	ding After fune	Certification;	27. Manyler of Death 1 Natural 2 Accident 3 Suicide 4 Demicide 6 Could not be determined	28a. Date of Inju (Month, Da	28b. Time of Injury	М	Injury at Work? 1 Yes	2 🗆 No	28d. Describe			l Route Number,
ਰ	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	cal Certl	29a. Certifier 1 Certifying Ph	building, et	c. (Specify) of my knowledge, deatl	occurred at the	he time d	ate and place	City or Tox	vn, State)	nd mannet as st	ated
	To the H within 24 To the F complete	Medical	one) 29b. Signafure and title of certifier	and manner st	f examination and/or in ated.		cense nur				signed (Month, i	
	10		39. Name and address of person who	ompleted cause of o	leath (Item 23a) (Typg.	Print) f	464	4	40	9/1:	3/05	
	1\		31. Date filed (Month, Day, Year)	19 9	Whom A	VP /	100	(M)	4018	177		
1	Sta Registr		SEP 1 6 2005	32. Hegistr	ar's Signature	وع			•			

State of Maryland / Department of Health and Mental Hygiere 30089 Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Year **Physician** Martha Avery 6:10PM M September 14.2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Clinton
If Under 1 Year | If Under 24 Hrs. 10504 Mullikin Drive Prince George's 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2 N F Months Days Hours Yrs. Director Nov 10, 1929 North Carolina 240 38 3099 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No XX Director Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10504 Mullikin Drive or Items 23a 20735 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (TYNo If Yes, Give 'A' Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after of Hygiene. other then "neturel", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 🏋 No Š Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygie Importent: If item 27 Is marked other tany injury or other treumatic event, In 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Craig Leroy Cranford Pauline C. Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeff Avery (Son) 10504 Mullikin Drive, Clinton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place Sept. 19, 2005 20a. Method of Disposition 20c. Location - City or Town, State 1 \$\mathbb{M}\$ Burial 2 □ Cremation 3 □ Removal from State Resurrection Cemetery * 4 □ Donation 5 □ Other (Specify) Clinton, Maryland 22. Name and Address of Facility Lee Funeral Tome. Inc. 21. Signature of Funeral price Licenses 6633 Old Alexandria Ferry RD Clinton, MD 20735 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Nan disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. physician Physician/Medicai the t as IF FEMALE: use If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 No Division of Vital Records, P.O. the detached à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24a. Was an autopsy performed' 1 ☐ Yes 2 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 No 1 Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one examiner Other: 4 Nursing Home 5 Hesidence 6 Other (Specify)

Injury at 28d. Pescribe how injury occurred ပ္ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: After Injury death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ca 29a, Certifier (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 46246 September 15, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 St. Ashraf Meelu M.D. Patrick Drive #408 Waldorf, Maryland 20603 31. Date filed (Month, Day, Year) 32. Pygistrar's Signature State SEP 1 6 2005 Registrar

		1	State of Maryland		rtment of Hetificate of L		lental Hygier		30090
ň	Physicia		Decedent's Name (First, Middle, Last)				2. Date of Death	Day Year	3. Time of Death
	/Medic Examin		Eva Applegate 4a. Facility Name (If not institution, give street and number) Mariner Health of Catonsville		4b. City, Town, or			4c. County of Deat Baltimon	h
T.	Funeral Director		5. Social Security Number $\begin{array}{c ccccccccccccccccccccccccccccccccccc$	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea APR 8, 19	ar) 9. Birtl	nplace (State or Foreign untry) ginia
	D	- H	Usual Residence of Decedent	Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	in the Ma or 28e-f s enotified	Directo	Maryland Baltimore 10e. Street and Number		10f. Zip Code	imore	10g.	Citizen of What Co	
	ems 23e o	ra .	5947 Prince George Street 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	2120 Was Decedent of Hi f Yes, specify Cubar		ecify Yes or No- Rican, etc.)	USA 14. Race - Ame Black, White	
0036	72 hours after death with the Maryland ineturel; or Items 23e or 28e-f show used Examinat must be multified at	by	1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates:		l □ Yes 2 No	Specify:	166	Specify:	White
7	⊆ -3	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L	kind of work done of DO NOT use retired, nemaker	furing most of work)	ing	Own Hor	ĺ
Maryland 2		Be	17. Father's Name (First, Middle, Last) Alfonzo Hicks				e (First, Middle, Maid e Branham		
aryli	2 should be and Mental is marked eumetic ev	6	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street a		al Route Number, Ci	ty or Town, State, 2	Zip Code)
ore, Ma	ss 1 and of Health i item 27 r other tr		Linda Ciarpello/Daughter 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State		Prince (sition (Name of natory or other place			timore, 1 Location - City or	
altimore,	permit. Pages Department of I Importent: If it eny injury or o		'4 Donation 5 Other (Specify) 21. Signature 1 Funeral Service Licensee	ro Cre	ematory,	Inc. 9/14	/05 Ba	altimore,	MD
Ba	Depa Impo eny i		Edward A Gregorchik	4	99 Freder	ick koad	of MD, Inc Baltimore	e, MD ZIZ	
	Physician	2 0	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. b.	ence of):	qetesu	mà			wky.
8	uted d ansit	Examiner	Sequentially list conditions, if any, leading to unimediate cause. Enter Underlying Cause (Disease or Injury that initiated events c.	mou uf):					
8760,	cate be executed physician and the burial-transit	dical Exa	resulting in death) Last Due to (or as a consequence) d.	ence of):					
.O. Box 68	The law requires that the death certifics the has been signed by the attending phoage 2 should be detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of deal 9 ☐ Unknown	death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date of de Month	ivery Day Year
s, D	uires that n signed by	d by Pr	Part II. Other significant conditions contributing to death but not result of feering like.			en in Part I.	23e. Did tobac 1 ☐ Yes		o the cause of death?
Division of Vital Record	The law require te has been sig age 2 should k	Completed	Osteomyelitis Chronic Atril S/P PEG	£6.	s'Uhin		24a. Was an autopsy performed 1 Yes 2	prior to death?	utopsy findings available completion of cause of
Vital	Physicien: 'this certifica	Be	25. Was case referred to medical examiner?		Oth		th <i>Check onl</i> one	2 5 0 th - 1 (Can	
on of	ding Phys n. After this funeral di	tion: To	27. Manner of Death 1 Natural 5 Pending (Month, Day Year)	R/Outpatier 28b. Time o Injury	of 28c. Injur Wor	y at	28d. Describe how		City)
Division	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At hor building, etc. (Specify,		reet, factory, office		28f. Location (Stree City or Town, S		ural Route Number,
	ne Hospitel 1 24 hours a 1 E Funerel I	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know one) 1 Medical Examiner: On the basis of examination and manner stated.	on and/or in	vestigation in my o	pinion death occu	rred at the time, date	and place, and du-	e to the cause(s)
	To the h within 24 To the F complete	M	29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 31. Date filed (Month, Day, Year) SEP 1 6 2005	rolig S	29c. Licens	6942	29d. Se	PL, 13,	200 5
	1/		30. Name and address of person who completed cause of death (Item 15 TORAKHIA, MD 1009, f	23a) (Type,	Print) Lick Rd	Catar	rille, M	0 2122	8
	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signat SEP I 6 2005	ure gos	e e	· · · · · · · · · · · · · · · · · · ·			

		1 - For State Registrar	State of Marylan	d / Depa <i>Cer</i>	artment of H	lealth and <i>Death</i>	Mental Hy	gien g	005	30091
q		Decedent's Name (First, Middle, Last)					2. Date of Do	eath Day	Yeer	3. Time of Death
Physicia /Medic		Bertha S. B.	osik				Aug.	20		5 815 PM
Examin		4a. Facility Name (If not institution, give stre				r Location of Dea			County of Deal	_
		Hillhaven Nursing Cer				MO 209			ince bec	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. 89	**1	Months Days	If Under 24 Hr Hours Mir	. (Month, D		, Co	thplace (State or Foreign buntry)
Director		Usual Residence of Decedent	87				NOV 10,	1915	Neu	VOLK
show		10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
e-f si	ctor	MD Prince Georg	el Ade	elphi						1 Yes 2 □ No
ith the	Oire	10e. Street and Number			10f. Zip Code	262			zen of What Co	ountry?
ath w	Funeral Director	3210 Powder Mill RS				783		USA		
er de items	nne	Tr. Marian States	Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No	S. 13. V	Was Decedent of his Yes, specify Cub	lispanic Origin? (an, Mexican, Pue	Specify Yes or Nato Rican, etc.)		 Race - Ame Black, Whit 	e, etc.
is aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	Yes 2 No	Specify:			Specify: Wh	rite
2 hou	ted	15. Decedent's Educat		16a. Deced	lent's Usual Occup	pation	- 4-1-	16b. Ki	nd of Business/	Industry
thin 7	Completed	(Specify only highest grade c	College (1-4or 5+)	life. E	kind of work done OO NOT use retire	d)	orking			
Aglen th	Con		5+	5	chool tea	T			school	
d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle	, Maiden	Sumame)	
y IC	To.	Nathan Goldstein	Deint	10b Mailia	- Addrson (Canad		a Alper	on Cin. o	Town State	Zin Code)
o, Infally failures Inc. 15.00000000000000000000000000000000000		19a. Informant's Name/Relationship (Type) Linda Diamond/daug	-	10	g Address <i>(Street</i> Flint			-		0853
Heal Heal tem 2		20a. Method of Disposition			sition (Name of natory or other pla		Date		cation - City or	
Pages nent of I		1 Burial 2 Cremation 3 Ren 4 Donation 5 Other (Specify)	iovai iiotii ptate		natory or other pla pard of May		129/2005	0.1	biomara M	20
교 교육원증		21. Signature of Funeral Service Licensee	11	22	. Name and Addre	ess of Facility				
Depariment of the particular o		Ronald S. W.	de Director		ate Anat Itimore,	omy Boar	d 655 W	Ba1	timore	Street
755		23a. Part1. Inter the diseare, or complice shock, wheart failure. List only one	ins that caused the death		*		ac or respiratory	ırrest,		Approximate Interval Between
Physician		Immediate Caus (Final disease or condition	DEMENTI	A						Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):						10000
LAGITITIE	_	Sequentially list conditions, if any, leading to immediate	ATHEROS		0>1>					15 YEARS
led sit	nine	Cause (Disease or injury	Due to (or as a conseq	uence or):						
al-trai	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):						
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d.								
tificat ng phy as th										
th cer tendir r use	Physician/M	23b. was decedent pregnant	. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnanc	v		1 2	23d. Date of del	
e dea he ati	sici	in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \)	4☐Pregnant at time of d		Other (specify) _	,			Month	Day Year
w requires that the death certific been signed by the attending pshould be detached for use as		9 ☐ Unknown Part II. Other significant conditions contri	buting to death but not rec	ulting in the u	adorhina onuca an	on in Part I	23e Did	tobacco u	se contribute to	the cause of death?
signe d be c	d by	Tarrit. Other signments continued to the	butang to death but not res	uning at trie di	idenying cause git	rasi ili r alt i.		Yes 2		
w requires to been signed should be	ete						24a. Was		T	itopsy findings available
he lay	Completed						auto perf	psy ormed?	prior to death?	completion of cause of
rician: Ticlian: Ticl	e C	25. Was case referred to medical				26 Place of De	1 ☐ Yes	2 X No	1 ☐ Yes	2.0 No
nysician: The law hysician: The law his certificate has b I director, page 2 sl	0 0	eyaminer?	pital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Ott		Home 5 ☐ Res		Other (Spe	cify)
7) 7 = 0	T iuc	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju- Wo		28d. Describe			
eath.	catic	2 Accident investigation				Yes 2 □No				
or Attending after death. Director: Attending lin by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify)	ome, farm, str y)	eet, factory, office			Street an wn, State		ural Route Number,
pital burs a erei C		29a, Certifier 1 Certifying Physic	ian: To the best of my kno	wiedee death	a accurred at the ti	ma, date and place	and due to the	221122(2)	and manner of	stated
To the Hospital or Attending Physician: To the Hospital or Attending Physician: To the Funarel Director: After this cartification of the Funarel Director. After this cartification is the funeral director.	edical	(Check only 2 Medical Examine one)	r: On the basis of examina and manner stated.	tion and/or inv	estigation, in my	opinion, death occ	curred at the time	date and	place, and due	to the cause(s)
To th withir To th comp		29b. Signature and title of certifier	2, .		29c. Licens	se number		29d. Dat	e signed (Monta	h, Day, Year)
		· Chullell &	Mun		V	51565		SOFI	tmock	9,000
		29b. Signature and title of certifier 30. Name and address of person who come CHAPLES Mr BEN 31. Date filed (Month, Day, Year)	pleted cause of death (Item	23a) (Type,	Print)	D DENE	# 205 0	ILVE	RSPRIN	5 MO 2090)
O to		31. Date filed (Month. Dav. Year)	22. Registrar's Signa	iture				10.0	4 melt is	11
Sta Registr		SEP 1 6 2005	22. Registrar's Signa	Good	le					

		-	1- State of Maryland / Dep	partment of Health and Men Prtificate of Death	tal Hygiene	005 30092
			Decedent's Name (First, Middle, Last)		Date of Death Month Day	3. Time of Death
	Physici /Medio		HALLIE M. BROWN	16	Tember 13	2005 2:00 PM
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. C	County of Death
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	pallinere City vi If Under 1 Year If Under 24 Hrs. 8 n	Date of Birth	N A 9. Birthplace (State or Foreign
	Funeral Director		213 · 82 · 5449 1 M 200 F 71 Yrs.	Months Days Hours Min.	Month, Day, Year)	9. Birthplace (State or Foreign Country)
	pc ,		Usual Residence of Decedent			
	death with the Maryland ms 23a or 28a-f show f must be rotified at	٦	10a. State 10b. County 10c. City, Town or MD RAITIMORE GUIVAIA			10d. Inside City Limits 1 ☐ Yes 2 M No
	the M	Funeral Director	MD BALTIMORE GWYNN 10e. Street and Number	10f. Zip Code	10a Citiza	en of What Country?
	23a or	ă	2718 BOWERS	21207	Tog. Chize	USA
	death ms 2:	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Specify	Yes or No-	4. Race - American Indian,
9	ours after death v ai', or items 23e	F.	1 Never Married 2 Married 1 ∨ Se 2 No It Yes 2 No It Yes 6 Ye	If Yes, specify Cuban, Mexican, Puerto Rical 1 ☐ Yes 2 ☑ No Specify:		Black, White, etc.
903		d by	3 MaxiMidowed 4 □ Divorced Year or Dates:			BLACK
5	filed within 72 hours after Hygiene. kther than "natural", or ite sht, the Medical Examina	Completed	(Specify only highest grade completed) (Gi	edent's Usual Occupation re kind of work done during most of working . DO NOT use retired)	166. KING	d of Business/Industry
212	e filed within Il Hygiene. other than vent, the M	шо	Elementary/Secondary (0·12) College (1-4or 5+) CAR	E PROVIDER	CHI	LD CARE
nd	be filed within 72 ho tal Hygiene. d other than "natu event, the Medical	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (Fire		iumame)
Maryland 21215-0036	ss 1 and 2 should be fi of Health and Mental F i item 27 is marked ot r other traumatic ever	2	HENRY MCGILL	CALLIE BR		
Mar	d 2 sh th and 7 is m traum			iling Address (Street and Number or Rural Roll KNOTTINGHAM RD.		
	item 2	1 3	20a. Method of Disposition 20b. Place of Dis	position (Name of Date	BALTO . M	ation - City or Town, State
mo m	Pages ent of nt: # i		1 & Buriai 2 Cremation 3 Li Hemovai from State	rematory or other place) U FOREST 09.19.0	5 MANA	IGS MILLS MD
altimore,	permit. Pages 'Department of himportant: if ite any injury or of once.		GINICIZO	22. Name and Address of Facility AUGHN C. GREENE FUN		
8	88188		Vangha C	151 BAUD. NATL PIKE, E	SALTO. MO	21229
			23a. Part1. Ent the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or res	piratory arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)			Offset and Death
	/Medical Examiner		Due to (or as, a consequence of):	uto D. L. F.		
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ystem Dysfunction		
	outed Id ransit	Examine	Cause (Disease or Injury that initiated events			
0,	cate be executed physician and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):			
8760,	cate b physic the b	dlcal	d			
9 x	ath certifi attending for use as	0	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		22	3d. Date of delivery
Box	death a atter d for u	by Physician/M	in the past 12 months? 1 Ves 2 Pour 4 Pregnant at time of death	B Ectopic pregnancy Control (specify)		Month Day Year
P.0	that the de ad by the detached	hys	9 Unknown			
	se gu	by F	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		e contribute to the cause of death?
ord	w requir been si should	ted	18 poralion Melmoria		1 ☐ Yes 2 ☑	No 3 Probably 4 Unknown
3ec	e taw has b	Completed	Kenal failule.		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital Records,			OS Management and the state of		1□ Yes 2☑No	1 Yes 2 No
	ysiclan: is certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpat	ent 3 DOA Other: 4 Nursing Home		Other (Specific)
Division of	fing Phy I. After this funeral o		27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28d.	Describe how injury	
sior	ending Faath. or: After he funer	atlo	2 Accident investigation	M 1 Yes 2 No		
Νį	or Attend after death Director: A	Certification	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. I	ocation (Street and City or Town, State)	Number or Rural Route Number,
	pital		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	oth convenient the time date and place and	due to the course(a) a	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) (Check one) (Check only one) (Check only one) (Check one) (Check only one) (Check only one) (Check one) (arr occurred at the time, date and place, and c investigation, in my opinion, death occurred at	the time, date and p	ind manner as stated. place, and due to the cause(s)
	To the To the Comple	Me	29b. Signature and title of certifier	29c. License number	29d. Date	signed (Month, Day, Year)
	~		Nikhil Hgaswal, MD	RES-000	Septe	ember 13, 2005
1	0		30. Name and address of person who completed cause of death (Item 23a) (Type N / K / M D	e. Print)	Ball:	~~
	Sta	ate	30. Name and address of person who completed cause of death (Item 23a) (Type Nikuti Herman MD) 31. Date filed (Month, Day, Year) SEP 1 6 2005	hadel	CD()	-, (
	Regist	rar	SEP 1 6 2005 Days A			

Pathert Rowshas Hallie Brown.

Patient Inoun as Dallas Burton

		1 - State Amend Item	State of Maryland / De 29c per Dr., G847	partment of Health a 09/16/05dbbeath	nd Mental Hyg	ien 2 0 0 5	30093
Physici	20	1. Decedent's Name (First, Middle, Last)			2. Date of Deal	th Day Year	3. Time of Death
/Medic		Dallas Burton			SEPTEMBE	ER 3 2008	5 06 13AM
Examin	er	4a. Facility Name (If not institution, give s	reet and number)	4b. City, Town, or Location of	Death	4c. County of Dea	th
		SINIAL HOSPITAL	OF BALTIMORI	- BALTIMORE	CITY		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthd	Months Davs Hours	Min (Month, Day	Yeari (a	thplace (State or Foreign ountry) unk
Director		220-64-6055 Usual Residence of Decedent	50 Yrs		Jan 2,	1955	
and		10a. State 10b. County	10c. City, Town o	Location			10d. Inside City Limits
Many f	ō	MD	Baltimo	ra			1√∑Yes 2 No
28a	Director	10e. Street and Number	Dareimo	10f. Zip Code	1	0g. Citizen of What C	ountry?
with po e		300 Metro Plaza		21215			outiny.
eath	Funeral		2. Was Decedent Ever in U.S.	3. Was Decedent of Hispanic Orig	in? (Specify Yes or No-	USA 14. Race - Am	erican Indian
Hen Item	ä	1 Never Married 2 Married	Armed Forces? 1 □ Yes 2 □ No unk	If Yes, specify Cuban, Mexican,	Puerto Rican, etc.)	Black, Whi	
urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: wl	nite
2 hou	ed	15. Decedent's Educ	ation 16a. De	cedent's Usual Occupation	unk	16b. Kind of Business	/Industry unk
Media	pie	(Specify only highest grade Elementary/Secondary (0-12)	completed) (G College (1-4or 5+)	ive kind of work done during most e. DO NOT use retired)	of working		din
i with	Completed	unk ur					
ent,	a	17. Father's Name (First, Middle, Last)		unk 18. Mother	's Name (First, Middle, I	Maiden Sumame)	unk
ld be lenta ked	To B						
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. Other traumatic event, the Maylical Examinating must be invalibled at		19a. Informant's Name/Relationship (Typ	e, Print) 19b. M	ailing Address (Street and Number	r or Rural Route Number	, City or Town, State,	Zip Code)
and 2 ealth a m 27 fa		Sinai Hospital	240	01 W. Belvedere	Avenue Balt	imore, MD	21215
t He G		20a. Method of Disposition	20b. Place of Di	sposition (Name of crematory or other place)		20c. Location - City or	Town, State
Pages nent of I		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State	I I			
그 든 쁜 글		21. Signature of Funeral Service License Ronal d S		.22. Name and Address of Facility	1 (55 77	- 1. A	
permit. Depart Import any inj		Konard S. W		22. Name and Address of Facility State Anatomy BC		Baltimore	Street
		23a. Part1. Enter the disease, or complic	ations that caused the death. Do not	Baltimore, MD 2 enter the mode of dying, such as o		est,	Approximate
200		shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.	1			Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Liver	ai lure			
Examiner			Due to (or as a consequence/bf):				
	-	Sequentially list conditions, b.	Due to for as a consequence of	ucephalopath,			
ted	Examiner	cause. Enter Underlying Cause (Disease or injury					
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icate be executed physician and the burial-transit	alE						
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the death certific by the attending p	N.	IF FEMALE: 23	c. If yes, outcome of pregnancy			23d. Date of de	livon
atter for u	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
the d	ysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	oli ottor (apocity)			
res that igned by be deta		Part II. Other significant conditions cont	ributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
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w require been si should t	Completed				24- 146	045 14/2-2-2-	
has has	шр				24a. Was a autops perform	y prior to	utopsy findings available completion of cause of
ysician: The is certificate hidirector, page							2 No
iclar certif	Be	25. Was case referred to medical examiner?	ospital:	Othor	of Death (Check only on		
Phys this	1.	1 Yes 2, No	28a. Date of Injury 28b. Tim	TIERT 3 DOA 4 NUI	sing Home 5 Reside		cify)
ding P h. After funer	loi	1 Natural 5 ☐ Pending	(Month, Day Year)	y Work?		w injury occurred	
er death rector: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be	One Blace of leiver 44 hours form	M 1 Yes 2 N			
or A or A or A Direct	Ħ	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town	reet and Number or Ri n, State)	urai Houte Number,
To the Hospital or Attending Physician: The law requires that the death certifully 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director. page 2 should be detached for use a		200 Cartillos 1760-111 1	alan Tarka kanada da		W.		
To the Hospital within 24 hours of To the Funeral I completely filled	edical	(Check only 2 Medical Examin	cian: To the best of my knowledge, der: On the basis of examination and/o	eath occurred at the time, date and r investigation, in my opinion, deatl	i place, and due to the ca h occurred at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
thin 2 the mple	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License number	20	9d. Date signed (Mont	h Day Yearl
N IN IN IN	_	200. Signature and this or certifier		Res 000	2	-	1
		Su vasqui K	MD.			SEPKMB	er 3 2005
ł		30. Name and address of person who cor	A .			,	er 3 doos
1		31. Date filed (Month, Day, Year)	CHHGANT 1 P	10 SINAL	HOSPITAL	OF BA	CTIMORE
Sta Registr		SEP 1 6 200	32 Registrar's Signature	parte			,
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			1- State of Maryland / Department / Departmen	artment of Health and M rtificate of Death	ental Hygier	2005 30094
	Physici		1. Decedent's Name <i>(First, Middl</i> e, <i>Last)</i> Carolyn Rose Bohan		2. Date of Death Month September	3. Time of Death r 11, 2005 9:20 p ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	Funeral		416 Campus Hills Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Bel Air If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Harford 9. Birthplace (State or Foreign
	Director		184-01-0163	Months Days Hours Min.	June 13,	9. Birthplace (State or Foreign Country) 1916 Pennsylvania
	anyland show	_	10a. State 10b. County 10c. City, Town or Low Md. Harford	Bel Air		10d. Inside City Limits 1 ☐ Yes 2 No
	r 28a-f	recto	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	ath with	Funeral Director	416 Campus Hills Drive	21015		.S.A.
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 ie marked other than "neturel", or Items 23a or 28a-f show any injury or other treumetic event, irs Marical Exactinet is sail to ricalified at ance.	by	1 Never Married 2 Married 1 Yes 2 XNo	Was Decedent of Hispanic Origin? (Spe if Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 ∰ No <i>Specify:</i>	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	ithin 72 ho Je. han "netur e Mudical	Completed	(Specify only highest grade completed) (Give life. College (1-4or 5+)	dent's Usual Occupation kind of work done during most of workil DO NOT use retired)	ng	Kind of Business/Industry
2	filed w Hygier other th	Be Col	12 years homem. 17. Father's Name (First, Middle, Last)		(First, Middle, Maide	own home
ylan	ould be Menta varked setic ev	To B	William Lippert	Rose Pi		
	nd 2 sh alth and 27 le rr ir treurr			ng Address (Street and Number or Rura Campus Hills Driv		
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altin	mit. Pa partmer portent y injury ce.			Crematory 9/14/ 2. Name and Address of Facility Chimunek Funeral H		ltimore, Md.
6	99 5 5 8		1/CU100/ 6	10 W. MacPhail Roa	d. Bel Ai	r, Md. 21014
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	denocará no ma		Approximate Interval Between Onset and Death Months
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	ificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
68760,	ate be o hysicial the buri	edlcal f	d			
O. Box 6	Attending Physicien: The law requires that the death certific r death. ector: After this certificate has been signed by the attending p by the luneral director, page 2 should be detached for use as	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
rds, P.	quires that an signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the u	ndertying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
Division of Vital Records,	: The law requir cate has been si page 2 should	Completed			24a. Was an autopsy performed?	
Vits Vits	yeicien s certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatien	26. Place of Death		6 □Other (Specify)
o uo	ding Phye h. After this funeral dir		27. Manner of Death 1 ★Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how in	
Divisi	or Attending after death. Director: After din by the funer	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, tte)
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deatl 2 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurred	and due to the cause(and at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
)	To the within 2 To the complete	M	29b. Signature and title of certifier	29c. License number D 36425	29d. 0	Date signed (Month, Day, Year)
1	0,		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) Ve Ste 425, Bel 1	Air, ND,	21014
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 6 2005	inter		

Amend item/1,6, Perby, FH, 9847, 9716/05 II State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registrar 30095 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Leon Billups, Jr. Day **Physician** Month Year 4:49 AM September 8 accs /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospital Baltimore Randallstown Northwest If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Yrs. Director 213-62-7897 50 10 54 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ral', or itams 23a or 28a-f show Examiner must be notified at XXYes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5703 Gwynn Oak 21207 U.S.A. by Funeral Ave 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black "natural" ted traumatic avant, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Complet al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Laborer Various Jobs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental and Menta Leon Billups Cora V. Johnson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I 5703 Gwynn Oak Ave, Baltimore, Md 21207 Michelle Billups-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Importent: If it any injury or o 1 Burial 2 Premation 3 Removal from State
4 Donation 5 Other (Specify) Metro Crematory Inc. 9/14/05 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 23a. Part1. Enter a disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardrovascular Disease Atherosclevotic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examine Bolmonam typentension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence ner b The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami Fibrillatio Amal that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death Month Day Year 5 Other (specify) Division of Vital Records, P.O. detached the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2) or Attending Physicien: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 8 2005 40055644 dress of person who completed cause of death (Item 23a) (Type, Print)

Less Hospital 5401, Old Coool Rely Bandallstown Nortewest Huspital 31. Date filed (Month, Qa Par) 6 2005 32. Registra is Signature State Registrar

State of Maryland / Department of Health and Mental Hygier 2005 30096 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEFTEMBER D BROWN **Physician** WHEELER 12 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RANDALLSTOWN BALTIMORE HOSPITAL CENTER NORTHWEST If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **№** M 2 F Months Days Hours Director 239-48-0801 NO Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 🎗 🗆 No MD Directo Baltimore Randallstown the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3845 Elmcroft 21133 U.S.A. Funeral Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
The filed T is marked other than "natural; or flee and yor other traumatic event, I'm Marical Excending ury or other traumatic event, I'm Marical Excending ury 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Supervisor J.E. Smith Company na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wheeler Brown Sr. Mary Hopkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3845 Elmcroft Road Randallstown, Md Roberta Brown-Wife 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 № Burial 2 Cremation 3 Removal from State permit. Page
Department of
Important: if
any injury or 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 9/17/05 Randallstown, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4399 Wabash ave, Baltimore, Md 21215 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) · CEREBRO VASCULAR **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequential v list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or). The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown INFECTION. TRACT 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy DIABETES MELLITUS. 1 ☐ Yes or Attanding Physician: ours after death.

Neral Director: After this certifical filled in by the funeral director, I 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{Specify} \) 1 ☐ Yes 2 No 1 patient 2 ER/Outpatient 3 DOA ٥ 28a. Date of Injury (Month, Day 27. Menner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated 29b. Signature and tyle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2723 BEFTEMBER 12 2005 e of death (Item 234) (Type, Print) NORTH WEST HARISH TLOI OLD 100501TAL RSTMBD Name and address of person who completed cause MD 21133 COURT 31. Date filed (Month, Day, Year) 32. Regitrar's Signature State 1 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygier 0 0 5 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Sept 12, 2005 Mildred Bromley 8:00 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bradford Oaks Nursing Home Clinton Prince George's 7. Age (In yrs. last birthday)
Yrs. Wonths Days Hours Min. Sept 22 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 6. Sex **Funeral** 1□ M 2√X Sept Director 578 12 0928 1920 Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 17 is marked other than "netural; or Items 23a or 28e-f show traumatic event, the Medical Exactive must be notified at 10d. Inside City Limits 1 Yes 2 No Director Prince George's Maryland Upper Marlboro 10e. Street and Number 10g. Citizen of What Country? 9132 Goldenrod Lane 20772 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 17 No If Yes, Give A. Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours atternent of Health and Mental Hygiene.
int: If item 27 is marked other than "netural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White Completed by ¥ ♥ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Clerical Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles W. Seville Laura Muck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trau Owen G. Bromley (Son) 13601 Lewisdale Road, Clarksburg, MD 20871 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Place of Disposition (Name or cometery, crematory or other place) Sept 16, 2005 1) Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Cheltenham, Maryland 21. Signature of Funer of Service Licensee 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d Mus X. Hus Alexandira Ferry Rd, Clinton, MD 20735 mo0257 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury or as a consequence of Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a tor use as the burial-P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Probably 1 ☐ Yes 2 ☐ No 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) ٩ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) hours after within 24 hours are To the Funeral Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and Atle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 20 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 30098 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 14, **Physician** 2005 MARY GALE BUGGS 3:08 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mariner Health Care of Laurel Prince George's Laurel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, NOV . 24, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1918 1 ☐ M 2 🗓 F 266-26-7521 86 Yrs Florida Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Items 23a 11911 Blackwood Court 20708 USA Completed by Funeral fited within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 23 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 3√ Widowed 4 Divorced Black "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Education 12 should be fited with and Mental Hygien 7 Is marked other th 12th 5+ Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James T. Brown Zara Cully 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traum once. Diane Dorinda Dix/Daughter 11911 Blackwood Court, Laurel, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 □ Donation 5 □ Other (Specify) West Arundel Crem. 9/15/2005 Odenton, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD ₩01103 23a. Part1. Extend the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Urinary Tract Infection disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Anemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Useass or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed **Renal Failure** and resulting in death) Last Due to (or as a consequence of) Box 68760, the attending physicien Failure to Thrive Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 Yes 24 No Day Year 4 Pregnant at time of death 5 Other (specify) P.O. detached ģ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXUnknown Completed been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has 1 Yes 2 No Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death Check onl one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 🔀 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 1 Alatural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29c. License number 29b. Signature and 4 29d. Date signed (Month, Day, Year) D26556 September 15, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7350 Van Dusen Road, #130, Laurel, MD Dr. Eaton 20707 31. Date filed (Month, Day, Year) 32. Raistrar's Signature State

Registrar

1 6 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2015 30099 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dana L. Booker September 15, 2005 1:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Chesapeake Hospice House Linthicum Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours 1 ☐ M 2 🖾 F Yrs. 65 Director 476-40-6011 California FEB 19, 1940 Usual Residence of Decedent Maryland 10b County 10c. City, Town or Location 10a State 10d. Inside City Limits Item 27 is marked other then "netural", or iteme 23a or 28e-f show other treumatic event, the Medical Evanimer must be multipled at 1 ☐ Yes 2X No Director Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 504 Fanleaf Court 2 should be filed within 72 hours after death and Mental Hygiene.
Is marked other then "netural", or Iteme 23 21144 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hotel / Elementary/Secondary (0-12) 12 College (1-4or 5+) Pharmaceutical Customer Service Rep. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Shelton M. Johnson Marie Martha Collier ္ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sinent of Health an ent: If Item 27 is is 504 Fanleaf Court Severn, MD 21144 e of Disposition (Name of 20c. Locat George A. Booker, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Depertment of Importent: If It any injury or o 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Metro Crematory, Inc. 9/16/05 Baltimore, MD 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Cremation Society of MD, Inc.

Edward A. Gregorchik

23. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** conce east /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 4 Preunant at time of death the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 2 No Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Whatural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel D Hospitel 29a. Certifier 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 39 505 September 15, 2005

Registrar

DHMH 17 Rev 1/2001

State

305

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

SEP 1 6 2005

100, Print) It is the Burn

Sae A. Barber 05-06192 RPD

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	Physici /Medio		1. Decedent's Name (First, Middle, Last, Sue A. Barber					2. Date of De Month Septemb	Day Year	3. Time of Death 2346 P M
	Examir		4a. Facility Name (If not institution, give Franklin Square H	ospital		Rosedale			4c. County of Death Baltimore	<u> </u>
7	Funeral Director		5. Social Security Number 6. Security Number 1 C	7. Age (in yrs	: last birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min.		th ay, Year) 9. Birth Co. Oh	nplace (State or Foreign untry) 10
	72 hours after deeth with the Maryland natural', or Itama 23a or 28a-f ehow disal Exartical termulified at	Director	10a. State 10b. County Md Baltimo		ity, Town or Lo	ocation Rosedale	9			10d. Inside City Limits 1 ☐ Yes 2 No
	eeth with t	eral Dire	10e. Street and Number 7912 32nd Street	et 12. Was Decedent Ever in U	10 10	10f. Zip Code 212			10g. Citizen of What Co	
920	172 hours after deeth with the Marylan Instural', or Itama 23a or 28a-f ehow Idical Examilian at mant ke mulified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	Amed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	реслу Yes or No to Rican, etc.)	Black, White	
Maryland 21215-0036	. 22	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup b kind of work done DO NOT use retired LPN	ation during most of wo d)	rking	16b. Kind of Business/I	ndustry
land 2	ould be filed Mental Hygis arkad other atic evant, tr	To Be Co	17. Father's Name (First, Middle, Last) Edward Miklews	ıki		LPN		ne (First, Middle,	Nursing Maiden Sumame)	ноше
	ges 1 and 2 should be filed within t of Health and Mental Hygiene. If item 27 ie marked other than or other traumatic event, the Me	-	19a. Informant's Name/Relationship (Ty Mr. Matthew S.	pe, Print)		ng Address (Street Fieldva	and Number or Ri	ural Route Numbe	er, City or Town, State, Z	ip Code) 1237
Baltimore,	permit. Peges 1 Depertment of He Important: If item any injury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	emoval from State	. Star	osition (Name of matory or other place nislaus	9/		20c. Location - City or 1 Baltimore	
Bal	Deper Impor any in		21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or compl	ml	12	aczorows 201 Dunc	lalk Av	e. Balt	imore, Md	
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Asphyxia Due Complicating Due to (or as a conse	To Ob Cocai	struction	Of Airw			Approximate Interval Between Onset and Death
68760,	ficate be executed physicien and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	,					
P.O. Box 6	law requires that the death certific es been signed by the ettending f c should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown		23d. Date of delin Month	very Day Year			
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f Vit	Physician: Tribis certificetral director, ps	To Be	25. Was case referred to medical examiner? ↑★★es 2 □ No	ospital: 1 Inpatient 2 🛭	ER/Outpatier	nt 3 DOA Oth		ath <i>(Check only o</i> Iome 5 ☐ Resid	ene) dence 6 ⊟Other (Speci	ify)
ision c	Attending Pirited Attending Pirited Attentions After the funeral by the funeral	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	Fourthern, Day Year) 9-9-05		P M Nor	yat k? Yes 2 X ∫No		now injury occurred	unk
Div	To the Hospital or Attending I within 24 hours efter death. To the Funaral Diractor: After completely filled in by the funer	I Certif	4 Homicide determined	28e. Place of Injury - At I building, etc. (Speci Scene sicien: To the best of my kn	ify)		an data and alone	way, Ros	Street and Number or Rur wn, State) 8733 Pu sedale, Md	ılaski high-
	To the Hoo within 24 h To the Fur completely	Medical	one)	ner: On the basis of examin and manner stated.	ation and/or in	vestigation, in my o	pinion, death occu	rred at the time,	date and place, and due t	to the cause(s)
	Twit		29b. Signature and the of certifier	,		O.C.M			29d. Date signed (Month, September 1	
5	1			10, MD	111	Print) Penn Stre		imore, M	Maryland 212	-
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 6 2	32. Registrate Sign	ature	Coole				

υΠ	AEL CAR	ΙXΙ	NGTON 1 - For State Registr <u>AMEND</u> ITEM	State o	of Maryla To MERCS	ind / Depa	artment of dificate of	Health <i>Death</i>	and M		iene 00!	5 30101
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7	Examin	er	4a. Facility Name (If not institution, JOHNS HOPKINS				4b. City, Town, BALT	or Location IMORE			4c. County of I	Death A
	Funeral Director		5. Social Security Number 216-68-2594	5. Sex 1X□M 2□F		s. last birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country) N.C.
H	D		Usual Residence of Decedent		47					2-27-	36	
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	death ms 23	Funerai	11. Maritaf Status	12. Was Dec	cedent Ever in	U.S. 13. V	Was Decedent of f Yes, specify Cul			cify Yes or No-		American Indian,
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Ë	Pages ment of tent: If it jury or o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		· Otato		rmel Ce)	9-19	-05	Dundal	k, Md
Baltimore,	permit. Page Depertment Importent: if eny injury o	Н	21. Signature of Funeral Service Li	censee	14		. Name and Addr				timore,	
n	20E 2		Joseph	KU	alle		March I					orth Ave.
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F	Physician (Modical		fmr ediate Cause (Final di sase or Condition resulting in death)	- a. Muy	Hiple,	inmen	5					Onset and Death
	/Medical Examiner			Due to	(or as a conse	equance of):						
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Division	Atter	ifice	3 Suicide 6 Could no 4 Homicide determin	ed 286. Plac	e of Injury - At	home, farm, stre	eet, factory, office			28f. Location (Str	eet and Number o	r Rural Route Number,
ā	tal or	Certification;	4 El Homolde	Duile	ding, etc. (Spec	street	_		2	City or Town.		Himire Mi)
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After it completely filled in by the funera		Check only 212 Medical E.	Physicien: To the	e best of my kr	nowledge, death	occurred at the t	ime, date a	nd place, a	and due to the ca	use(s) and manne	or as stated. due to the cause(s)
	the	Medical	one) A 29b. Signature and title of certifier	and ma	nner stated.							
	Z W W		7 / 1.	1 9 /	1			C.M.E			od. Date signed (M SEPT. 13	
	\mathcal{X}		30. Name and address of person w	no completed car	ise of death (Ite	em 23a) /Tunn	Print\					
	,)		ZABIGUI					BALT	IMORE	E, MARYLA	ND 21201	
	Sta	te	31. Date filed (Month, Day, Year)	32	Registrar's Sign	nature	.0					
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			State of Maryland / Department of Health and M 1- State Registrar Certificate of Death	lental Hygier	2005	30102
			Registrar 1. Decedent's Name (First, Middle, Last)	Reg. 2. Date of Death	No.	3. Time of Death
	Physici		Emma Comegys	Month	Day Year 12 2005	7:05 A.M.
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. Qty, Town, or Location of Death		4c. County of Death	
			Forest Haven Nursina Home (atonsvill	e	Balt	more
	Funeral		5. Social Security Number 6. Sex 7. Age (In) yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye.	9. Birth	nplace (State or Foreign
	Director		Usual Residence of Decedent	Sept. 2,	1914 Nor	th Carolina
	yland		10a. State 10b. County 10c. City, Town or Location	<u> </u>		10d. Inside City Limits
	a-f st	ctor	Maryland NIA Baltimore			1 XYes 2 □ No
	or 28	Director	10e. Street and Number Apt. 10f. Zip Code	10g.	Citizen of What Cou	untry?
	s 23a		124 W. Franklin St. 1202 2/201		USI	4
	Item Item	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent of Hispanic Origin? (Spr. 13. Was Decedent of Hispanic Origin? (Spr. 15. No.	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
99	hours after death with the Maryland tural', or Items 23a or 28a-f show at Examinat must be multised at	by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates: 1 □ Yes 2 X No Specify:		Specify: P	lack
21215-0036	72 ma	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work)	ing 16b	. Kind of Business/I	ndustry
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2	filed v Hygie other t		17. Father's Name (First, Middle, Last) Detense Worker 18. Mother's Name	e (First, Middle, Maid	berdeen K	roving Ground:
Maryland	Mental Merkad o	To Be	Alfred Talley Ella	R 60.1	1 A	
ary	2 should be and Mental is marked a	-	19a. Informant's Name/Relationship (Type, Print) (Spn) 19b. Mailing Address (Street and Number or Rura	al Route Number, Cit	y or Town, State, Z	ip Code)
_	rt 2		Mr. Saul Comeaus 102 N. Stockton	St. Ba	Ito. Md	21223
ore			20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		Location - City or T	own, State
Ë	Pages iment of lant: If it		'4 □Donation 5 □Other (Specify)	2005/	unsdou	une, Md.
Baltimore ,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility To Seph L., Russ F	uperal	Home, P. A	<i>t</i> .
			23a. Party Enter the disease, or complications that caused like death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory arrest,	Md. 21210	Approximate
	Physician		Immediate Cause (Final			Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):			
	Examiner		Sequentially list conditions. b			
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	be executed sician and burial-transit	Examiner	that initiated events c			
8760	at the death certificate be executed I by the attending physician and etached for use as the burial-transit	dical E	d.			
9	tificate ng phys as the	a u				
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Eclopic pregnancy		23d. Date of deliv	,
O.	ne dea the at hed fo	Physician/M	in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{VNO} \) 9 \(\text{Unknown} \) Unknown		Month	Day Year
Ω.	that the de led by the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did tobacc	o use contribute to	the cause of death?
Vital Records,	es pe pe	d by	grant and discontinuing states of the states	1 ☐ Yes	2 No 3 Pro	
CO	w requir been si should	lete		24a. Was an	24h Ware aut	onsy findings available
Re	The lav	Completed		autopsy performed	death?	opsy findings available ompletion of cause of
ita		a	25. Was case referred to medical 26. Place of Death	1 Yes 2 7	No 1 □ Yes	212 No
	S S	To B	examiner/	me 5 Residence	6 ☐ Other (Spec	ify)
n of	of Plant		1 Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how in	ijury occurred	
Sio	Attending r death. actor: After by the fune	icat	2 Accident investigation M 1 Yes 2 No	00() (0)		
Division	or Al after of Dirac in by	ertification:	4 Homicide determined determined determined 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St.		al Route Number,
	Hospital 4 hours a Funaral I	O	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the cause	(s) and manner as	stated.
	To tha Hospital or Attending Phwithin 24 hours after death. To the Funaral Diractor: After thi completely filled in by the funeral	edicai	(Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurrence) and manner stated.	ed at the time, date a	and place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier 29c. License number	29d. I	Date signed (Month)	Day, Year)
	0		Jameen Hallan 1) 28575		1/2/0	
0	2		30 Name and address of persod who completed cause of death (Item 23a) (Type, Print) ASNOEM AKHAMI, 7220 PARK HEIGHTS A 31. Date filed (Month, Sax, Year) 6 2005 32. Registrar's Signature	YE. RA	m An	91216
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	INA	(1)	420
şč.	Registr		SEP 1 6 2005 Steeler It foods			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** September 14, 2005 12:50AM Pia Hegglin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery Casey House | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 19, 10 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 1 M 2 X Yrs 1936 Switzerland 69 139-32-0208 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 No Director Maryland Montgomery Rockville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 6716 Tildenwood Lane Switzerland Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates: δ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Elsener Alois Johann Hegglin ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6716 Tildenwood Lane Rockville, MD 20852 Daniel F. Case/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition September 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 15, 2005 Arundel Crematory Odenton, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Ws a Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a Ovarian Carcinoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Disease or in jury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): by Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown

Physician /Medical Examiner

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The law requires that the death certificate be executed

Physicien:

Hospitel or Attending

Division of Vital Records, P.O. Box 68760,

filled in by the

Completed

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2

Certification:

Medical

State

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

5 Pendina

SEP 1 6 2005

investigation

1 ☐ Yes 2 X No

27. Manner of Death

1 X Natural

2 Accident

3 Suicide

4 T Homicide

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

September 14, 2005

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No was autopsy performed? 1 ☐ Yes 26. Place of Death (Check only one) Other: $_{4\square}$ Nursing Home $_{5\square}$ Residence $_{6}$ Other (Specifyhospice

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

D35635

6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

29a Certifier i 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

Hospital:

Joseph Kaplan M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 307 M **Physician** 2000 /Medical 4c. County of Death Name (If not institution, give street and num 4b. City, Town, or Location of Death **Examiner** 8. Date of Birth

Month, Day, Year)

JULY 17, 1950 If Under 1 Year | If Under 24 Hrs. 6 Sex last birthday **Funeral** 1 M 2 F Days Hours Min Director al Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No MD PACTIMORE Director 10f. Zip Code 10g. Citizen of What Country? or items 23a Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 IVNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, per it. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Exantinat 1 ☐ Mever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TEACHER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ALSTON 260RGE 19b. Mailing Address (Street and Number or Rural Route Number, 19a. Informant's Name/Relationship (Type HAR FORD ROAD BAN, MD 21234 ASHONDKA (DAVGHTER) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Deurial 2 Cremation 3 Removal from State ARBUTUS, MARY LAND ARBUTUS CEMETERY 20.05 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee BALTO, RoAD MO 21212 23a. Part1. Enter the disease, or contributions that caused the death shock, or heart failure. List only one use on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Division of Vital Records, P.O. Box 68760. attending physician by Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 ☐ Yes 2 SNo
9 ☐ Unknown 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? g to death but, ot res ging in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner?
1 Yes 3 No
27. Manner of Death
1 Natural 5 Hospital: Other: P 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 2 No investigation 1 ☐ Yes 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Vedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

6 2005

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 CLEMENTS, LIONEL 30105 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Clements Lionel SEPT. 9 2005 1555 P /Medical 4a. Facility Name (11 not institution, sixe street and number)
MARYLAND HOSPITAL 4b. City. Town, or Location of Death CLINTON 4c. County of Death
PRINCE GEORGES Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 23, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F 435 42 8135 72 Yrs. 1933 New Orleans, LA Director Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ma 23a or 28e-f short must be notified at 1 □Yes 2 □ No Director Louisiana Orleans New Orleans XX 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2325 Alver Street 70117 United States Funeral r than "natural", or itema 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Afro-American 1 ☐ Yes 2000No Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Retia1 permit. Pages 1 end 2 should be filed w Department of Health and Mental Hygier Important: if Item 27 Is marked other it any Injury or other traumatic event, ILS ODG. 6th Coffee Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eva Joseph Clements 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernestine Clements (wife) 2325 Alver Street, New Urleans, LA 70117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Lee Crematory Sept 12, 2005 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD 21. Signatura of Funeral Service Floens 22. Name and Address of Facilit Lee Funeral Home, Inc 6633 Old m00257 Alexandira Ferry Rd, Clinton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiovascular Hypertensive attended Physician /Medical bue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-translt Due to (or as a consequence of): Box 68760, by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No 24a. Was an hes autopsy performed? 1 Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient examiner? 1X Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 XER/Outpatient 3 □ DOA of this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E SEPT. 10, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARIIA (I MAH) ALA 111 PENN STREET, BALTIMORE, MARYLAND 21201 ABILICIAN 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 6 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien O O C

	Dharaini		State Amend Item1&Un Registrar 1. Decedent's Name (First, Middle, Last)						aur	2. Date of De	ath		3. Time of Death
	Physicia /Medic				Raciii					SEPTEM		1, 2005	1052 A
	Examin		4a. Facility Name (If not institution, give	street and number)					cation of Death		4c. Co	ounty of Death	
×			BAYVIEW HOSPITAL 5. Social Security Number 6. Secu	7 Age	e (In yrs. las			IMORE (Under 24 Hrs.	8. Date of Bir			ace (State or Foreig
	Funeral Director			IM ALL	46	Yrs.	Months		tours Min.	8. Date of Bir (Month, Da May 23	y, Year) 1959	Coun	rland
	land ow		10a, State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Limit
	r death with the Marylan ems 23a or 28a-f show ermust be notified at	ţċ	Maryland Balt:	imore				I	Edgemere	9			1 ☐ Yes 2X ☐ N
	or 28	Director	10e. Street and Number				10f. Z	ip Code			10g. Citize	n of What Coun	try?
	th will		2400 Lincoln Ave	nue Lo	ot 24				L219			ed Stat	
21215-0036	4 within 72 hours after death with the Maryland liene. 1 than "natural", or Items 23a or 28a-f show the Micilcal Examinat must be notified at	by Funerai	11. Marital Status t:Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent to Armed Forces? 1 ☐ Yes 2 2 2 4 1 1 Yes, Give Year or Dates;				edent of Hispa ecify Cuban, I 2 3 No S		ecify Yes or No Rican, etc.)		. Race - Americ Black, White, pecify: Wh	
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Maryland	ould be fil Mental H arked otl atic even	Be	17. Father's Name (First, Middle, Last) James H. Chipps					10		et M. Si		imame)	
2	d 2 should be filed th and Mental Hyg 7 Is marked othe treumatic event,	၉	19a. Informant's Name/Relationship (T)	me Print)		19h Mailir	na Addre	ss (Street and		ral Route Numb		own State Zio	Code)
<u>s</u>	d 2 sho th and t7 is mu trsum		Mr. James H. Chip		r)		-			ındalk,			
d)	f Health f Health ltem 27 other tr		20a. Method of Disposition		20b. Pla	ice of Dispo	sition (N	ame of other place)		Date	20c. Loca	tion - City or To	wn, State
OE.	Pages ent of nt: If I		1 ☐ Burial 2 【XCremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)				-		rp. 9/15	5/2005	Tow	son, Ma	ryland
Baltimore,	permit. Pages i Department of H Important: If Ite any Injury or ot ance.		21. Sandure of Funeral Service Licens		20	Di	Name ida-	and Address of RUCK Fu	Facility ineral I	Home of			
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23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respire shock, or heart failure. List only one cause on each line. Physician /Medical / Medical / Medic							or respiratory a	rrest,		Approximate Interval Between Onset and Death			
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	tificate be executed ig physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events	o									
Ö,	sian a	E	resulting in death) Last	Due to (or as	a conseque	ance of):							
68760,	rtificate b ng physic as the b	edical		d									5.890
.O. Box 6	The law requires that the death certificate has been signed by the attending I age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3]Ectopic] Other (pregnancy specify)			23	d. Date of delive Month	ery Day Year
<u>α</u>	quires that n signed by uld be deta	δ	Part II. Other significant conditions co	ntributing to death b	ut not result	ting in the u	nderlying	cause given	in Part I.		obaccouse Yes 2 💢		ne cause of death? eably 4 ∐Unknow
I Records,	The law require ate has been si page 2 should t	Completed								24a. Was auto perfe	psy ormed?	prior to co death?	psy findings availab mpletion of cause o 2 No
/ita	Physicien: The I r this certificate ha ral director, page	Be	25. Was case referred to medical examiner?	1					6. Place of Dea	th (Check only	one)		
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ů c	After Annorg	on	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	f M	28c. Injury at Work?	s 2 □No	28d. Describe	now injury (occurred	
Division of Vital	Attend r death sctor: ,	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj					2 2 1140		Street and i	Number or Rura	d Route Number,
ā	s afte	Cert	TOTTICIO	building, et	(Specify)					City of 10	, o(a(0)		
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Month 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. De									tated. the cause(s)				
	To th within To the	Me	29b. Signature and title of certifier	. 0	1 -		2	9c. License n			29d. Date SEPTE	signed (Month,	Day, Year) 2, 2005
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		-	Taska Zavoonk	era M. D				STREET,	BALTIM	ORE, MA	RYLAN	D, 2120	1
	St	ate	31. Date filed (Month, Day, Year)	32. Registr	rar's Signati	nte				-			
	Regist			1	4.	1	ABO B						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2015 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 1934 6 ERALDING CHASE 9 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIU OF WID- SHOCK-TRAUMA BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Days Months Hours 1 ☐ M 2 😿 F 51 217-62-1274 7/7/54 Director MARY UND. Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No NA Baltimore Director MD or 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with or Items 23a 628 N. Payson Street 21217 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: 3 Nidowed 4 □ Divorced **Black** 'natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Computers 11 Data Entry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental I Ruth Elliott Jerry Dargan ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health (1533 Kathleen Drive Columbia, SC 29210 Deborah K. Sharp/Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot once. cemetery, crematory or other place 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory 09-14-05 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor Street. Balto, MD 21217 Approximate Interval Between Onset and Death 232 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician ARREST CARDIAC disease or condition resulting in death) HOURS /Medical Due to (or as a consequence of): Examiner LIVER YEARS DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit wain ItEmo THORA that initiated events resulting in death) Last Due to (or as a consequence of) sician Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYDER TENSION 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? MOLBID ORESITY 24a. Was an page 2 autopsy performed 2□ No 2 No 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 🕱 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Magner of Death 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated To the within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

2

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

StateRegistrar

31. Date filed (Month, Day, Year) SEP 1 6 2005

O'CONNOR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Greene ST, BAC

DO057930

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		Maryland / Depa	delible Ink. Ensur artment of Health ar rtificate of Death	-	² 005 30108
	Decedent's Name (First, Middle, Last)			2, Date of Death	3. Time ol Death
Physician /Medical	Norma P. Callis	6.4	4 0 T		
Examiner	4a. Facility Name (If not institution, give street and num Stella Maris	Der)	4b. City, Town, or Location of Timonium	Death	4c. County of Death Baltimore
Funeral Director		7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year If Under 24	Min (Month, Day, Ye	9. Birthplace (State or Foreign Country) 1927 Virginia
e Maryland Ba-f show lifting at	10a. State 10b. County SC. Beufort	10c. City, Town or Lo	ead Island		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
3a or 2	10e. Street and Number 12 Dahlgren Lane		10f. Zip Code 29928	10g.	Citizen of What Country?
ore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Medical Examinar must be multiled at To Be Completed by Funeral Director		2 [XNo	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, 1 Yes 2 No Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036 ed within 72 hours att gglene. It is the Medical Exami	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-+2	4or 5+) (Give	dent's Usual Occupation kind of work done during most of DO NOT use retired)	of working	Own Home
Maryland 2121 nd 2 should be filed within th and Mental Hygiene. 27 is marked other than " traumatic event, the May To Be Compile	17. Father's Name (First, Middle, Last) Lenwood Perdue			s Name (First, Middle, Maid istine Furr	- '
re, Mariand 2 she Health and 1 lem 27 ls man other traum	19a. Informant's Name/Relationship (Type, Print) Mrs. Barrie C. Brown/ Da		ng Address <i>(Street and Number</i> Barron Court To		
Baltimore, permit. Pages 1 ar Department of Hea mportant: If Item may injury or otherans.	20a. Method of Disposition 1 Deurial 2 Commation 3 Removal from S	IAIA	matory or other place)		Location - City or Town, State
Baltimore permit. Pages 1 Department of H Important: If Ite any injury or ot	4 Donation 5 Other (Specify) 21. Signature of Fureral Service Licensee				Towson, Md.
a 88 5 8 8	23a. Part1. Enter the disease, or complications that ca	used the death. De not see	Ruck Towson Fu 1050 York Rd.	Towson, Md. 2	Approximate
Physician /Medical Examiner Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		CELL LUNG CANCE	R	Interval Between Onset and Death
68760, gifticate be exemple; so the burial-edical Ex	d				
P.O. Box 68760, that the death certificate be ex ed by the attending physicien a detached for use as the burial Physician/Medical E)	23b. Was decedent pregnant 1 Live bir	int at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
S, P. es that igned by be deta	Part II. Other significant conditions contributing to dea	ath but not resulting in the u	nderlying cause given in Part I.		co use contribute to the cause of death?
ecord aw requir as been s 2 should				24a. Was an autopsy performed	
/ital	25. Was case relerred to medical examiner?			f Death (Check only one)	
on of Vital Relating Physician: The International Affector, page functor, page Iton; To Be Com		patient 2 ER/Outpatier		ing Home 5 Residence	
anding anth. or: Afte	27. Manner of Death 1 TNatural 5 Pending (Month) 2 Accident investigation	, Day Year) Injury	f 28c. Injury at Work? M 1 Tyes 2 No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Division Completely filled in by the funeral Director: After completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined 28e. Place of buildin	ol Injury - At home, larm, sti g, etc. (Specify)	eet, lactory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
o the Hospi thin 24 hour o the Funer empletely fill	29a. Certifier (Check only one) 1 Certifying Physician: To the late of the la	sis of examination and/or in	h occurred at the time, date and vestigation, in my opinion, death	place, and due to the cause occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the within To the compl	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)
	-		D4372	1	9/15/05
Q	DR. TARIQ MAHMOOD 2300	DIII.ANEY VALLI	TTMONTU	M, MD 21093	
State Registrar	31. Date filed (Month, Day, Year) \$2. R	gistrar's Signature	barle		

30109

			1 - State Registrar		Ce	rtificate of	Death	,	Reg. No.		30103
			1. Decedent's Name (First, Midd	le, Last)				2. Date of De		Voor	3. Time of Death
	Physicia /Medic		Mabel Lorena Di	uBree				Sept	01, 20	05	2235 M
	Examin		4a. Facility Name (If not institution			4b. City, Town, o	r Location of Death	1	4c. County	of Death	
			Harford Memoria			Havre d			Harfo		
	Funeral Director		5. Social Security Number 217-22-0013 Usual Residence of Decedent	1 N 2 VE	n yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 06/24/1	ay, Year)	9. Birthp Cour Cana	place (State or Foreign ntry) Ud.A
	land		10a. State 10b. County	11	0c. City, Town or Lo	ocation				1	IOd. Inside City Limits
	Mary f sho	ro	MD Harko	n d	Havre de	Grace					1 ☐ Yes 2 ☑ No
	28a	Director	10e. Street and Number	cu	mavile at	10f. Zip Code			10g. Citizen of	What Cour	ntry?
	3a ol		3810 Wilkinson	Road		21078			Canad	ά	
	deati	Funerai	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No		ce - Americ	can Indian,
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	by	1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	ned 1 ☐ Yes 2 💢 No		1 ☐ Yes 2 ☑ No	Specify:	o moan, etc.)	Specif	ck, White, ^{'y:} Wh	
5-0	72 hc	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor	king	16b. Kind of B	usiness/In	dustry
2	within ene. than "	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)			d)				
7	filled v Hygie other t		7th 17. Father's Name (First, Middle,	(ast)	HOI	nemaker	18. Mother's Nan	ne (First Middle	Hom Hom		
and	ntal hed of	Be		Lusty				et Black		10)	
Maryland	should the	²	Archibald Daga	ship (Type, Print)	19b. Maili	ng Address (Street				State Zir	Code)
\mathbf{z}	and 2 sho saith and n 27 is ma		John D. DuBree-	San		Churchvil					,
ē,	s 1 and 2 f Health Item 27 othar tra		20a. Method of Disposition		20b. Place of Dispo			Date	20c. Location -		own, State
Baltimore,	t. Partmer		1 ☑ Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (\$ 21. Signature of Funeral Service	Specify)	Rock Run	Cemetery	09/0		Havre de		
Ba	Depermine Deperm		21. Signature of Pulleral Service	m Smith	M	2. Name and Addre itchell-S 3 S. Wash	mith Fun	eral Hor	ne, P.A.	ND (71076
		-	23a. Part 1. Enter the disease, o	r complications that caused the	e death. Do not en	5 S. Wash ter the mode of dyin	unglon,	or respiratory a	rrest.	MU	Approximate
ı	Dharisian		shock, or heart failure. List Immediate Cause (Final	t only one cause on each line.	D I		=1	<1	1		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Acute Due to (or as a c	onsequence of):	1ary 1	cdema	WH	K		1 day
r	Examiner			A Cul	2 10	soivat	11111 1	5.1	1110		
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	onsequence of):	· hiral	VX	α	TV C		
10	cuted nd ransii	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C		,					
0,	e exe ian ai urial-t	EX	resulting in death) Last	Due to (or as a c	onsequence of):						
68760,	ertificate be executed ling physician and is as the burial-transit	edicai		d							
9 ×	ertific ling p	Med	IF FEMALE:	220 14							
.O. Bo	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 [4 Pregnant at tirr	Fetal death 3	Ectopic pregnancy Other (specify)				te of delive onth	ery Day Year
Q	res that i		Part II. Other significant conditi	ons contributing to death but r	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use cont	ribute to th	ne cause of death?
Vital Records,	quires n sign	d by	Severe	Demen	tia			1 🗆 '	Yes 2 No	3 🗆 Prob	ably 4 Unknown
00	w requir s been si should	ompieted	Condin	100,100				24a. Was		Were auto	psy findings available
Re	The law ate has page 2	дшс	- Carano	myo pa	<u> </u>				psy prmed?	prior to cor death?	mpletion of cause of
tal		e C	25. Was case referred to medica	11	<u></u>		26. Place of Dea	th (Check only o		1 🗌 Yes	20 No
\geq	S S III	O B	examiner?	Hospital: 1 Inpatient	2 ER/Outpatier	nt 3 DOA Oth	oc.		dence 6 □Oth	er (Specif	y)
J of		n; T	27. Man of Death 1 Natural 5 Pendi	28a. Date of Injury (Month, Day Y	ear) 28b. Time o	f 28c. Injur	y at	28d. Describe	how injury occur	red	
<u>i</u>	Attending or death. octor: After by the fune	atic	2 ☐ Accident invest	igation			Yes 2 □No				
Division	l or Attendate deatl Director:	Certification;	3 Suicide 6 Could 4 Homicide determ	nined 28e. Place of Injury building, etc. (At home, farm, str Specify) 	reet, factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rura	l Route Number,
	Hospital or 4 hours afte Funaral Dir tely filled in										
	To the Hospital or Attentwithin 24 hours after deatl To the Funaral Director: completely filled in by the	edicai	29a. Certifier 1 Certifyi (Check only 2 Medical one)	ng Physician: To the best of n Examiner: On the basis of ex and manner stated	amination and/or in	n occurred at the tin vestigation, in my o	пе, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and ma date and place,	inner as st and due to	tated. the cause(s)
	To the I within 2. To the I complet	ž	29b. Signature and title of certifie	1 1		29c. Licens	e number		29d. Date signe	d (Month,	Day, Year)
)	/		11/a	my//WX	-ND	DI	9583		septem	nber	~ 2,2000
	h		30. Name and address of person	who completed cause of deat	h (Item 23a) (Type,	Print)	& Lai	V. Sti	reet		121,001
	シ		21 Data filed (Marth Pay Year	M- 42	ATTA SIGNAL	MD	Mei	deei	>, M	ary	land
	Sta Registr		31. Date filed (Month, Day, Year SEP 1 6 20	05 See 32. Registrar's	aignature (, 1		,	/	

MABEL DUBREE

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiena Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SUSAN Year **Physician** DUCKETT SEPT 2005 6-45AM 12 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Gensis Eldercare-Brightwood Ctr. Timonium Baltimore If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea 8 - 1 - 1960 Birthplace (State or Foreign Country) **Funeral** Months Days 1□ M 2以 F 45 Yrs. 217-80-4956 Director Marvland Usual Residence of Decedent be filed within 72 hours after death with the Maryland al Hygiene.

other than "natural", or frems 23a or 28a-1 show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Gwynn Oak Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5511 Belleville Avenue 21207 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. African XX Never Married 2☐ Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2√☐ No Specify: Specify: American à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Security Guard Watkins Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 end 2 should be f Department of Health end Mental I Important: If Item 27 Is marked of any injury or other traumatic eve Leonard Turner <u>Mary Duckett</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5511 Belleville Avenue, Mary Duckett/Mother Balto. MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation Woodlawn Cemetery 9/20/05 Woodlawn Malt.co. Other (Specify) 22. Name and Address of Facility 9200 Liberty Rd., Randallstown, aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. av1. Enter the disease or complications that lock, or heart failure. List only one cause of Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical NETASTATIC CANCER TO LIVER monuto Examiner Due to (or as a consequence of) Physician/Medical Examiner anding physician end usa as the bunal-trensit or Attending Physician: The law requires that tha death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 ☐ Yes 2 1 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Menuter of Death 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 🛂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) & MD 8pup D0053150 SEPTENBER 1241 200 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) GUPTA 9650 SANTIAGO Sh ALEUNIYACA 32 Registrar's Signature

DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Month, Day, Year)

6 2005

State of Maryland / Department of Health and Mental Hygien 2005 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 14 2005 **Physician** June Lucille Dettor 5:40 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Timonium Mercy Ridge If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

Months Days Hours Min.

August 5, 1921 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F 84 Yrs. Director 220-09-5927 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at Director 1 Yes 2 No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 USA 613 St. Francis Rd. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Printing +1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be White Collier Norma James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3107 Morning Side Ct. Baldwin, Md. 21013 Stephen Varanko, Jr/ Friend item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Commetery, crematory or other place)
4 Donation 5 Cother (Specify Entombment Dulaney Valley Mem. 9-17-05 Timonium, Md. 22. Name and Address of Facilit Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Cardionyopatzy **Physician** ears /Medical Examiner S quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown à After this certificate has been signed funeral director, page 2 should be def Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? periorr 2**0.**No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Patural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Checa unity 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D58303 September 14 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Powermo 21204 6601 N. Charles ST Charles MO 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State 6 2005 Registrar

INC LUCITH DETTOR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** HERONICA +LYNN 2005 /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VKESUI Woods BrINTON Nursing Carro If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Months Days 148, 12, 2523 1 □ M 2 🗗 98 1906 New Jersey Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Directo MD Carrol1 Sykesville 10e Street end Number 10f. Zip Code 10g. Citizen of What Country? 1991 Bennett Road 21784 <u>USA</u> 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: white Completed by Specify: 3 Widowed 4 □ Divorced Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 0 homemaker own home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Cook Hooker Barbara Elizabeth Rouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Loretta O'Connor/daughter 1994 Bennett Road Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ⑤ Cremetion 3 ☐ Removal from State 9/4/05 atomy Board BAlto 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Runeral Service Licensee de, Director State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) several v Due to (or as a consequence of) Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequenca of): Physician/Medical Due to (or as a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 TYes 2 No 3 □ Probably 4 □ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? 2 1 No 1 ☐ Yes 2 ☑ No 1 ☐ Yes Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Varsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 2 Natural 5 Pending investigetion 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. edicai 29a. Certifier

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 peen this To the Hospital o within 24 hours of To the Funeral DI completely filled in

signed by the attending physician and d be detached for use as the burial-transit s certificete has b director, Director: After this in by the funerel

Funeral

Director

filed within 72 hours after death with the Marylend Hygiene.

pamit. Peges 1 and 2 should be filed i Dapartment of Health and Mentel Hygie Important: If Item 27 ie marked other i any Injury or other traumatic event, #

Baltimore, Maryland 21215-0036

r than "natural", or frame 23s or 28s-f show the Medical Examiner must be nothed at

State

31. Date filed (Month, Day, Year) SEP 1 6 2005

HTRICK

29b. Signature end title of cartifier

(Check only one

> 1000 1 Registrar's Signeture

un sus

IRNES OUD

address of person who completed cause of deeth (Item 23a) (Type, Print)

ORIGINAL

29c. License number

20806

ELDERSBURG, MI)

29d. Date signed (Month, Oay, Year)

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DHMH 16 Rev 6/95

Registrar

			1 - For State Registrar	State of Ma	Ce	artment of H rtificate of L	lealth and Men D <i>eath</i>	nai mygier Rag. <i>t</i>	1º2005	30113
## T	Physici /Medi		1. Decedent's Name (First, Middle, La:	lond.			2.	Date of Death	Day Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give SINAI HOSPITAL			4b. City, Town, or BALT	Location of Death	,	4c. County of Death	<u> </u>
	Funeral Director		5. Social Security Number 6. S 245-16-7891 Usual Residence of Decedent	ex 7. Age ☐ M 2[]£F	(In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8. [Hours Min.	Date of Birth Month, Day, Yea V . 11, 1	ur) 9. Birthp Cour .910 South	place (State or Foreign ntry) 1 Carolina
	a-f show	ctor	10a. State 10b. County		10c. City, Town or Lo				1	10d. Inside City Limits 1√2 Yes 2 □ No
	ath with the	rai Director	10e. Street and Number 3912 DORCHESTER R	OAD		10f. Zip Code 212	207		Citizen of What Cour	ntry?
936	urs after de al', or itame Xeminer n	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	0	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2☑ No	spanic Origin? (Specify n, Mexican, Puerto Rica Specify:	Yes or No- n, etc.)	14. Race - Americ Black, White, Specify:	etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itame 23e or 28e-1 show any Injury or other traumatic event, the Medical Examiner must be inclified at once.	Completed	15. Decedent's Ec (Specify only highest gra	lucation	(Give	DO NOT use retired	luring most of working)	16b.	Kind of Business/Ind	BLACK dustry
land 5	ild be filed v lental Hygie 'ked other t Ilc event, Ib	To Be Co	10th 17. Father's Name (First, Middle, Last) NICHOLAS MCWHITE			HOMEMAKE	IR 18. Mother's Name <i>(Fir</i> MAMIE GII	st, Middle, Maide	DOMESTIC en Sumame)	
	and 2 shouealth and N m 27 is mai		19a. Informant's Name/Relationship (1 EFFIE GLOVER/SIST		1390	GLASSBORC	and Number or Rural Ro	ute Number, City		Code)
Baltimore,	iit. Pages 1 artment of H ortant: If Ite injury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Fundral Service Light))	20b. Place of Dispo		9-14-20		Location - City or To	
eg E	permi Depa Impo any Ir		234. Part1. Enter the disease, or companion shock, or heart failure. List only	1	Wi 12	lliam C. 06 W. Nor	Brown Comm. th Ave. Bal	timore,	1 Home P. MD 21217	Approximate
E. Carrie	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. ATTY	lynig .					Interval Between Onset and Death 40 m/s
68760,	icate be executed physicien and s the burial-transit	edical Examiner	Sequentially list conditions, if any, Leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):					
.O. Box 6	ath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. II yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date ol delive Month	ery Day Year
ords, P	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions of Dementa	ontributing to death but			n in Part I.	23e. Did tobacco	ouse contribute to the	ne cause of death? ably 4 □Unknown
al Rec	n: The law ficete has b or, page 2 st	Completed	25. Was case referred to medical	-			1	24a. Was an autopsy performed? Yes 2 N	prior to con death?	psy lindings available inpletion of cause of 200 No
Division of Vital Records, P.O. Box	To the Hospitel or Attending Physicien: The law within 24 hours elter death. To the Funerel Director: Attenthis certificate has completely filled in by the funeral director, page 2	ation; To Be	examiner?	Hospital: 1 ☐ Inpatien 28a. Date ol Injury (Month, Day		28c, Injury Work	4 Nursing Home			/)
Divis	itel or Atters selven der rel Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc.				City or Town, Sta		
	To the Hospitel or Attendi within 24 hours efter death. To the Funerel Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 1	ysician: To the best of iner: On the basis of e and manner state	examination and/or inv	occurred at the time estigation, in my op	e, date and place, and d inion, death occurred at number	the time, date ar	s) and manner as stand place, and due to rate signed (Month, L	the cause(s)
	- 3 - 3		Frank WA		ath (the second of	D 00	21730	250.0	State Signed (Month), E	1005
S.	Sta Registr		30. Name and address of pe in who of TARIQ KHAN 31. Date liled (Month, Day, Year)		ELVEDERE A's Signature	ř	MORE,MD 212	15		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygier 005 30114 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month bar **Physician** Errust (10, 7:05-PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SECOUR HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 09.23. Birthplace (State or Foreign Country) 6. Sex Funeral Months Days Hours 1 **X** M 2 □ F 220.20.1233 Director VA Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location rel', or Items 23e or 28a-f show Examinar must be notified at 1 XYes 2 No NA Director BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "neturel", or Items 23e or? 201 SOLLERS POINT 21222 ROAD USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 AYes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced 27 Is marked other than "neturel", traumatic event, the Medical Exa Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SHIP BUILDER 12 TH GRADE NA HIM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) IHALBERT FOWLKES LULA CRAWILEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other trat once. (DAUGHTER) 3613 SOLLERS POINT RD., BALTO. MD 21222 DIANA FOWLKES 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 09.16.05 CROWNSVILLE MD * 4 ☐ Donation 5 ☐ Other (Specify) CROWIUSVILLE 21. Signature of Funeral Service Licensia 22. Name and Address of VAUGHN C. GREENE FUNERAL SERVICE 5151 BAUD, NATT PIKE BAUD. MD 21229 Vansh 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) > Phis Syndrmu. Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical as attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by End stage To the Hospitel or Attending Physicien: The law requires VInal auseuse. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 2 9 No 2 No 1 ☐ Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Hnpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funerel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 45148 of person who completed cause of death (Item 23a) (Type, Print)
SUPNO 2000 West Buttwork Still Buttmore, Waryland 31. Date filed (Month, Pay Year) 3¢ Registrar's Signature 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Orville H. Fisher Sept 12, 10:44 P M 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Dec 31, 1 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 243 01 3463 Director North Carolina Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Item 27 is marked other than "neturel", or items 23a or 28a-1 show other traumatic event, the Madical Examinar must be notified at Prince George's 1 ☐ Yes 2 ☑ No Maryland Brandywine Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 16001 Ashbox Road 20613 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: if item 27 is marked other than "neturel", or ite Y⊠Yes 2 No 1 ☐ Never Married XX ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 217 Vio Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Airforce Military 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edmund Lloyd Fisher Gerhe VanHorn 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Fisher (Wife) 16001 Ashbox Road, Brandywine, MD 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept 19. 200520c. Location - City or Town, State 20a. Method of Disposition permit. Pages i Department of I Important: If Ite any Injury or ot XX Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral 8 Alexandira Ferry Road, Clinton, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** /Medical resulting in death) Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner certificete has been signed by the attending physicien and irector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Onknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 1 Ninpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Insert Section 2] Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier 24 and manner stated within 2 29b. Signature and litle of ceculier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrat's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

			For State Registrar		Maryland / De	partment of ertificate of	Health and No. 16 Death		gien 200	5 30116
	Physici /Medic		1. Decedent's Name (First, Middle, FRANCES	Last)	FULTO	N		2. Date of Dea Month SEPTEM	Dav. W	3. Time of Death
	Examir		4a. Facility Name (If not institution, H'ARBOR HOSPI	TAL		BAL	or Location of Death		4c. County of N/A	
	Funeral Director		5. Social Security Number 247-32-7458 Usual Residence of Decedent	5. Sex 7	. Age (In yrs. last birthd	Months Dave		8. Date of Birt (Month, Da) July 3		Birthplace (State or Foreign Country) S. Carolina
	s 1 and 2 should be filed within 72 hours after death with the Maryland it Health and Mental Hygiene. Item 27 ie marked other than "natural", or Items 23e or 28e-f show other treumatic event, the Medical Evaminatimust be notified at	Funeral Director	Maryland Anne 10e. Street and Number 216 Warfield 11. Marital Status	Road 12. Was Deced	Glen B	urnie 10f.Zip.Code 21060	Hispanic Origin? (Sp ban, Mexican, Puent		10g. Citizen of What USA - 14. Race - Black,	10d. Inside City Limits 1 □XYes 2 □ No at Country? American Indian, White, etc.
9-0036	2 hours after satural, or lical Examir	þ	1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced 15. Decedent's	If Yes, Give Year or Dat Education	es: 16a. De	1 ☐ Yes 2 ĀNo	pation		Specify:	Black ess/Industry
Maryland 21215-0036	12 should be filed within 7 h and Mental Hygisne. 7 le marked other than "n freumatic event, the Med	Completed	(Specify only highest Elementary/Secondary (0-12) 12th	College (1-4	4or 5+)		e during most of worked)		Private	Family
yland	iould be fil I Mental H narked otl	To Be	17. Father's Name (First, Middle, La David I	Howard			Mat	tie Bl		
Baltimore, Mar	t. Page rtment o rtent: If njury or		19a. Informant's Name/Relationshi Frances Thomas 20a. Method of Disposition 1★ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Li	S Norris	(Neice) 20b. Place of Di cemetery, Arbutu Park	216 War sposition (Name of crematory or other pla S Memori	9/17	d. Glen Date 7/05	Burnie 20c. Location - Cit Baltimo:	, Md. 21060 y or Town, State
Ba	Dermi Depa Impo any ii		23a. Part1. Enter the disease, or c	Reese M	OUY83	Wm. Rees 8211 We	ess of Facility e & Sons st St. A	Mortu Innapol	ary, P.	
	Physician /Medical Examiner	_	snock, or near tailure. List of Immediate Cause (Final disease or condition resulting in death)	a. CI Due to (or	BLEED ras a consequence of):		ing, storr as cardiac	or respiratory at	1631,	Approximate Interval Between Onset and Death Six Hours
8760,	cate be executed obysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisaere or in my that initiated events resulting in death) Last	C	r as a consequence of): r as a consequence of):					
.O. Box 6	The law requires that the death certific tie has been signed by the attending p tage 2 should be detached for use as:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼No 9 ☐ Unknown	1☐Live birt	nt at time of death	3 □Ectopic pregnanc 5 □ Other (specify)	су		23d. Date of Month	delivery Day Year
ords, P	w requires that been signed b should be deta	by	Part II. Other significant condition	s contributing to dea	th but not resulting in the	e underlying cause gr	ven in Part I.			te to the cause of death?
Vital Records,		Completed						24a. Was a autop perfor	sy prior	
of	ding Physician: 1 h. After this certitical funeral director, p	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manger of Death 1 Natural 5 Pending investiga	28a. Date of (Month,	Datient 2 ER/Outpa Injury 28b. Time Day Year) Injur	of 28c. Injury		ome 5 Resid	ne) lence 6 □Other (low injury occurred	Specify)
Division	or Atten atter deat Director: in by the	ertification;	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of	f Injury - At home, farm, g, etc. <i>(Specify)</i>			28f. Location (S City or Tow		r Rural Route Number,
	는 다구 아이	edical C	29a. Certifier (Check only one)	Physician: To the baseminer: On the baseminer	est of my knowledge, de is of exa <i>m</i> ination and/or r stated.	eath occurred at the tinvestigation, in my	ime, date and place, opinion, death occur	and due to the c red at the time, o	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the within 2 To the Complet	Σ	29b. Signature and title of certifier	MD		29c. Licen	se number		29d. Date signed (M EPTEMBER	Ionth, Day, Year)
			30. Name and address of person will ALI EMAMHOSS	EINI :	3001 S. HA		BALTIM			
	Sta Registr	ite ar	31. Date filed (Month, Ray Year)	6 2005 32. Reg	giarrar's Signature			,		-

			For State Registrar	State of M	arylan	d / De C	partment of e <i>rtificate o</i>	Health and M If Death		jier 2 0 0 5	30117
	Physic	an	Decedent's Name (First, Middle, Las				EEL DMAN		2. Date of Dea Month	Dav Y	3. Time of Death
	/Medi Exami		SADIE 4a. Facility Name (If not institution, give	B a street and number)			FELDMAN 4b. City, Town	n, or Location of Death	SEPTEME	4c. County of	
		-	HOSPICE OF BALT					TOWSON			ALTIMORE
	Funeral Director		5. Social Security Number 6. Security Number 215-40-9963	ex □M 2√x F 7. Ag	95 (In yrs. I	ast birthda Yrs.	Months Day		8. Date of Birth (Month, Day FEB. 27,	1910 9	Birthplace (State or Foreign Country) MD
NZ	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or	Location				10d. Inside City Limits
2005 AM	r 28a-f ehow	ctor	MD N/A			BAL	TIMORE				1 ∑ Yes 2 □ No
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17	deeth with the Maryland me 23a or 28a-f ehow	eral	3900 N. CHARLES	ST. #814	Ever in II	S 1:	3 Was Decedent	21218	acify Yes or No-	14 Race	USA American Indian,
cmbe 0036	72 hours after d natural', or iten dical Examinar	by Funeral	1 XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 💢 If Yes, Give Year or Dates:)	J. 11	If Yes, specify C	of Hispanic Origin? (Spuban, Mexican, Puerto No Specify:	Rican, etc.)		White, etc. WHITE
马马	72 ho natura	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. De	cedent's Usual Occ	cupation ne during most of work	ina	16b. Kind of Busin	ness/Industry
212.42	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life	CHER	ired)		WASH., D	.C. SCHOOL DIS
₹ and	9 E 9	Be	17. Father's Name (First, Middle, Last)				DMAN	18. Mother's Name	e (First, Middle, i	Maiden Sumame)	DEADMAN
ξZ	2 should be and Mental is marked o	2	JOSEPH 19a. Informant's Name/Relationship (7)	Type, Print)			DMAN	MINNA net and Number or Run	al Route Number	r City or Town Sta	BEARMAN
Ma Na	1 and 2 s Heelth ar om 27 is		STANLEY FINE / /				-	ES ST. #21:			
Ore.	8 - 2 0		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State		emetery, c	position (Name of rematory or other p	olace)		20c. Location - Cit	y or Town, State
altimor	permit. Page Depertment of Important: if eny injury or once.		4 □ Donation 5 □ Other (Specify)	HEBI			P CEM 09/1		BALTIMO	
Sadle Baltim	Deperment of the poore		21. Signature of Buneral Service Licen	litt	th			STERSTOWN I	ROAD - P		
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68760,	icate be executed physicien and s the burial-transii	edical		. d							
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P.O.	that the d ed by the detached	Phy	9 ☐ Unknowh * Part II. Other significant conditions or		ut not recu	Iting in the	undosh ing causa	Guan in Dart I	22 a Did tol	anno una contribu	ag to the gauge of death?
ords,	w requires tha been signed I should be det	ed by	Congestive	Heart	50	ul	cul	given in Part I.	1 T Y	-	te to the cause of death? Probably 4 Dunknown
Division of Vital Records,	The law rate has be page 2 sh	Completed							24a. Was a autops perforr	n 24b. Wer by prio ned? dea	e autopsy findings available r to completion of cause of th?
ita	ysicien: T is certificat director, p	BeC	25. Was case referred to medicat examiner?					26. Place of Death			Yes 2□ No
of V	Shysic this ce al dire	မ	1 □ Yes 2 No	Hospital: 1 ☐ Inpatie		P/Outpat	BILL SELDON			ence 6 Other (Specify tospice
ono	iding Ph th. After th funeral	tlon	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Da	y Year)	28b. Time Injury	v v	jury at Vork? ☐ Yes 2 ☐ No	28d. Describe ho	ow injury occurred	/
isi	Attendia ar death. ector: A by the fu	Certification:	3 Suicide 6 Could not be determined		ury - At ho	me, farm,	street, factory, offic		28f. Location (St	reet and Number of	or Rural Route Number,
Ō	itel or ins efte rel Dir lled in								City or Towr		
	To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours effer death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use e	Medical	one)	ysician: To the best liner: On the basis o and manner st	f examinati	vledge, de ion and/or	ath occurred at the investigation, in m	time, date and place, y opinion, death occurr	and due to the cared at the time, da	ause(s) and manne ate and place, and	or as stated. due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	1/) <	0.		29c. Lice	inse number	1	9d. Date signed (M	
	5		30. Name and address of person who	completed cause of o	leath (Vem	23a) (Tvn	e. Print)	77 200	0:	deterne	m /), ~005
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48	Sta Regist		31. Date filed (Month, Day, Year) . SEP 1 6 2	32. Registr	ar's Signat	ure					
*	i redisti	E-1	2EP 162	2005	120	B.	Bearles.				

DHMH 17 Rev 1/2001

ORIGINAL

Amend item#5, perFH, 1847, 919/05 TT Department of Health and Mental Hygiene 0 0 5 30118 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav 09-14-2005 <u>Charles Fink</u> /Medical 3:35 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilcrest Hospice Towson Baltimore Social Security Number 154-24-0964 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months 1 2 M 2 □ F 219-16-6525 Director 09-20-1932 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f ehow the Medical Examiner must be notified at Baltimore 1 Yes 2 No Directo Monkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? FINK September 14,2005 , or Items 23a 16217 Corbett Village Lane 21111 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 MYes 2 □ No If Yes, Give Year or Dates: Maryland 21215-0036 1. Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No þ Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced and Mental Hygiene. Is marked other than "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/AN/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ould be Mental permit. Pages 1 and 2 should be Department of Heath and Mental Important: If Item 27 Is marked eny injury or other traumatto ev 2008. Charles Fink Jr. Eleanor Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene Fink Brother 16217 Corbett Village Lane Monkton, Md 21111 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09-15-2005 Baltimore, Maryland Green Mount 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wise Funeral Services, P.A. 700 S. Beechfield Ave Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** Due to for as a consequence of): /Medical Examiner Due to ras a conducte of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed erebros Ascallal Due to (or as a consequence of). P.O. Box 68760 Physician/Medicai 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 3 ☐ Probably 4 Nunknown should b 1 TYes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate hes birector, page 2 s autopsy performed? 2 No 1 ☐ Yes 2 ZNo 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Dother (Specify) NOSPICE 1 ☐ Yes 2 No ٩ 3 DOA this After thi 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident within 24 hours after des To the Funeral Director completely filled in by th 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) and title of certifier 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 2005 30. Name and address of person who completed cause of death (Item 23a) (Type-Print) (doll N. Charles liastes (31. Date filed (Month, Day, Year) SEP 1 32. Registrar's Signature State 2005 Com It Sports Registrar

HAROLD FALLOWS

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			1 - For State Registrar	Otato o	Ce	rtificate of	Death		eg. No.	30119
ı	Physici		Decedent's Name (First, Midd Harold	Joseph	Fallows			2. Date of Deat Month Septemb	th per 13, 200	3. Time of Death 5 10:25 p M
	/Medi Examir		4a. Facility Name (If not institution	n, give street and number)			or Location of Death	· · · · · · · · · · · · · · · · · · ·	4c. County of Deat	h
H	Funeral		Stella Maris 5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthday	Timor		8. Date of Birth	Baltimo	TE hplace (State or Foreign
	Director		214-18-0321 Usual Residence of Decedent	1 X M 2□F	85 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, NOVETIDEL	2° 1919 Ma	ryland
	arylanc ehow	-	10a. State 10b. County	, Baltimore	10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	the Marylan 28a-f ehow notified at	recto	10e. Street and Number	parcimore	ו דוווטו	10f. Zip Code		1	0g. Citizen of What Co	
	th with 23a or	al Di	2525 Pot Spri	ng Rd., L 50	3		21093		U.S.A.	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 le marked other then "neturel", or Items 23a or 28a-f ehow any injury or other traumatic event, I'te Medical Exal, in artimust be inclified at ance.	by Funeral Director	11. Marital Status 1 Never Married 2 Na 3 Widowed 4 Divorce	If Yes Give	Ever in U.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origin? (Spectan, Mexican, Puerto For Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Uh	e, etc.
5-0	72 ho	eted	15. Decede (Specify only highe	nt's Education est grade completed)	16a. Dece	edent's Usual Occu	ipation a during most of working ad)	g	16b. Kind of Business/	
Maryland 21215-0036	s within iene.	Completed	Elementary/Secondary (0-12)	College (1-4or	D+)	alesman	9d)		Commercia Hardware	1
nd	al Hyg	Be C	17. Father's Name (First, Middle		_		18. Mother's Name			
yla	d Ment d Ment narked natic e	To			allows, Sr		Hele		Cart	
	alth and 2 st	. 8	19a. Informant's Name/Relation Bertha B. Fal				ng Rd. L 50		, City or Town, State, 2 nium, MD	21093
Baltimore,	ges 1 a t of Hei If item or othe		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation	3 ☐Removal from State		matory`or other pla	ace)		20c. Location - City or	
ltim	artmen ortant: injury		* 4 □ Donation 5 □ Other (3				ess of Eacility Ruck		Towson, MD Funeral H	
Ba	Depa Impo any ir	0 9	Mell	WITTIG	ii d. bdd -		k Rd., Tow			ome, inc.
60, A	/Medical / Medical / Medical supply sicion and supply suppl	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as b. Due to (or as c.	a consequence of): a consequence of): a consequence of):	FAILURE				Interval Between Onset and Death
.O. Box 687	The law requires that the death certificate to the law requires the tatending physicate 2 should be detached for use as the to a set the to the law to the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome	2 Fetal death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	cy		23d. Date of deli Month	very Day Year
ds, P.	ires that signed b	by	Part II. Other significant conditi	ons contributing to death b	ut not resulting in the u	underlying cause g	ven in Part I.		pacco use contribute to	
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Vital	yeicien: Th nis certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatie	nt 3□ DOA Ct	26. Place of Death		nce 6 XIOther (Spec	HOCDTCE
n of	ding Ph. h. After thi funeral		27. Manner of Death 1 ★ Natural 5 □ Pendi	28a. Date of Inju	ry 28b. Time o				w injury occurred	my/ HOST TCE
Division	deat deat ctor: / the	Certification;	2 Accident invest 3 Suicide 6 Could 4 Homicide determ	not be as Steep of Inc	ury - At home, farm, st c. (Specify)]Yes 2 □ No	Bf. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
	To the Hospitef or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical Ce	29a. Certifier (Check only one) (Check only one)	ng Physician: To the best Examiner: On the basis o and manner st	f examination and/or in	th occurred at the threath	ime, date and place, ar opinion, death occurred	nd due to the ca	use(s) and manner as ite and place, and due	stated. to the cause(s)
)	To the within To the	Me	29b. Signature and title of certific				se number	29	9d. Date signed (Month	, Day, Year)
_	211	1	30. Name and address of person	who completed cause of d	eath (Item 23a) (Type,		Charles of the Control of the Contro		111-11	
/	2TT	-	DR. TARIQ MAR 31. Date filed (Month, Day, Year		ULANEY VAL	LEY RD.	TIMONIUM,	MD 2109	93	
* */_	Sta Registr			6 2005	ar's Signature	parte				
DH	MH 17 Rev 1/2	001	U in i							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure Alf Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 005 30120 1- State Registrar AMEND ITEM #23b PER PHY G847 97 16405 of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Eleanore Zŝ Zras 5 of tember /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 5. Social Security Number Baltinwise If Under 1 Year If Under 24 Mrs.
Months Days Hours Min. Ton Xal 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 4 - 29 - 1918 Birthplace (State or Foreign Country) **Funeral** 10 M XXF Yrs. 87 Director 213-20-1067 Usual Residence of Decedent North Carolin 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Itams 23e or 28a-f show traumatic event, the Medical Extra front or mail to mailibal at Completed by Funeral Director IVID Baltimore
10e. Street and Number 1 ☐ Yes 2 No n/a 10f. Zin Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a any injury or other traumatic event, I a Medical Extra Institution once. 2214 Lawnwood Gircle USA 2 1 2 0 7

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes XXNo Specify: Specify:African American 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembly 8th Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bell Gill 2 Ernest Gill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Gill/Son Pine Run Ct., Ealtinore 20c. Location - City or Town, State 20a. Method of Disposition

20a Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Locus Grove * 4 ☐ Donation 5 ☐ Other (Specify) 9-20-2005 Vorth Carolina P.A. of Baltoco. Funeral Servi 22. Name and Address of Facility Wylie F/H P.A. of 9200 Liberty Rd., Randallstown, Part : Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Firysician Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner ASP retion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 X No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 27. Manner of Deat 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) Suptember 18. 2001-

State Registrar 12.3 Thyant Hospital Rangelston, heryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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Baltimore, Maryland 21215-0036

P.0.

Division of Vital Records,

		1 = For State Registrar	State of Ma	aryland	d / Depar <i>Certi</i>	ment of I	Health and I Death	Mental Hy	ygiene 005	30121
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Physici /Medio		Daniel E. Gri	ffin					09-	15 - 05	
Examin Funeral Director	er	4a. Facility Name (If not institution, give Franklin Square) 5. Social Security Number 6. S 219-20-5803	Hospital	l Cen e (In yrs. la 80	fer ast birthday)		or Location of Death A le If Under 24 Hrs. Hours Min.	0.0-140	4c. County of De Baltim irth Jay, Year) 9. E 13, 1924 Ma	ore
pu *		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Local	ion				
the Marylan 28a-1 show	ctor	MD Balti	more	TOC. City		ville				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
ath with th	Funeral Director	10e. Street and Number 8800 Walther B				10f. Zip Code 212			10g. Citizen of What	
5-0036 72 hours after death with the Maryland natural; or Items 23s or 28s-1 ehow dical Exambor must be modified at	d by Fune	11. Marital Slatus 1 □ Never Married	12. Was Decedent I Armed Forces? 1 (XYes 2 □ N If Yes, Give Year or Dates:			s Decedent of I es, specify Cub	dispanic Origin? (Si an, Mexican, Puerto Specify:	pecify Yes or No De Rican, etc.)		nerican Indian, hite, etc. hite
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Ind inal Hy od oth	To Be C	17. Father's Name (First, Middle, Last) Daniel J. Gri					18. Mother's Nam Fannie	,	e, Maiden Sumame)	
₩ 01 m = @		19a. Informant's Name/Relationship (, ,						ber, City or Town, State	
Fin Ire, M s 1 and 27 tree item 27 other tr		Eula Griffin /v	wile	20b. Pla	8800 ace of Dispositi	190.0	100000	. Balt	imore MD	21234
_ 0 0 0		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification Specification Specifi		Ce.	reland.	Memori	al 9/1	7/05	Baltimo	
Baltime Baltime permit. Pag Depa tment Important: h any injury o		21. Signature of Funeral Service Licen	/ 0	10		ame and Addre	Cor	nelly	FuneralHo	meofEssex
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Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Aspiro	tion	2 Prie		ia Bila		,	Interval Between Onset and Death 5 aus
S876(icate be physicia s the bur	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Acuto Due to (or as a c. Due to (or as a d.		ence of):	tory	ta: lure			& days
Division of Vital Records, P.O. Box 6 Hospital or Attending Physician: The law requires that the death certifi 24 hours after decords. Funeral Director After this certificate has been signed by the attending tely filled in by the funeral director, page 2 should be detached for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗀 Fetal o	leath 3 ⊟Ec	opic pregnancy her (s <i>pecify)</i>	,		23d. Date of d Month	olivery Day Year
S, P Bs that gned b	by Pi	Part II. Other significant conditions of	ontributing to death bu	t not resul	ting in the unde	tying cause giv	en in Part I.	23e. Did t	tobacco use contribute	to the cause of death?
ord:	ted	Cardiomyopat	hy				<u> </u>	1 🗆	Yes 2 2 No 3 □ F	robably 4 Unknown
al Rec	Completed	Malnutrition						24a. Was auto perfo 1 □ Yes	psy prior to death?	ulopsy findings available completion of cause of s 2 \(\sum \) No
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n of ng Phy ter this neral d	n: To	27. Mann of Death	28a. Date of fnjun (Month, Day	/ 2	R/Outpatient : 28b. Time of Injury	28c. Injun	4 - Nursing Ho		dence 6 Other (Sp	ecify)
isior Mtendin death. ctor: Af	catio	1		roar,			Yes 2 □ No			
Division of Vital Rectors to the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	4 Homicide determined	building, etc.	(Specify)		•		City or Tou		
the Hosp hin 24 hou the Fune upletely fi	Medical	29a. Certifier 1 Certifying Phyone) 1 Medical Exem	rsician: To the best o iner: On the basis of and manner stat	examinalic	ledge, death oc on and/or invest	curred at the tin gation, in my o	ne, date and place, pinion, death occurr	and due to the red at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
To the within To ut	Σ	29b. Signature and title of certifier	Az			29c. Licenson			29d. Date signed (Mon	
10		30. Name and address of person who o	ompleted cause of de	ath (Item 2	23a) (Type, Prin	in Sa	IACO DALL	a Bal	69-15-0 Himore Md	11227
Stat Registra		31. Date filed (Month, Day, Year) SEP 1 6 20	32. Registra	r's Signatu	10	· · · · · · · · · · · · · · · · · · ·	W16 211V	v vu /	1111117	1/201
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State

31. Date filed (Month, Day, Year) SEP 1 6 20 1 6 2005 Registrar

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 30123 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** edember 12 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4c County of Death Examiner Medical Cour If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) If Under **Funeral** 9. Birthplace (State or Foreign Country) Days 1 ☐ M 2 🔀 F Hours Director 42 Yrs 217-74-1744 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location iral', or items 23e or 28e-f show Examiner must be cutified at 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 No Md Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 8183 Midhaven Road USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Specify. White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ent: If item 27 is marked other then ury or other treumatic event, the Ment or other treumatic event. 12 Administrative Assistant Kelly Group 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis Michael Godack <u>June Rose Herbert</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1898 Church Rd. Baltimore, Md. 21222 Frank Godack / Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or * 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 9/15/05 Baltimore, Md. 21. Signature of Funeral Service Ligensee Kaczorowski Funeral Home P. A. kudo Dundalk Ave. Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner 44 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 3 ☐ Probably 4 Miknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 2 000 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 200 Other: Certification; To 1 patient 2 ER/Outpatient 3□ DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number (Type, Print) 32. Registre State Registrar

			1 - State Registrar	State of Marylan	d / Depa <i>Cer</i>	rtment of He tificate of D	ealth and M <i>eath</i>	ental Hygier Reg. I		30124
I	Physici	an	Decedent's Name (First, Middle, Last) LOWELL	T, HAWK	ins			2. Date of Death	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, Town, or L	ocation of Death		O ZOO 4c. County of Dea	
				ARE CATONS			SVILLE	MD,	BALT	
	Funeral Director		CC0.38.2034	7. Age (In yrs. I	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yes 10 - 27 - 192	9. Bir	thplace (State or Foreign buntry) MD
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	e Marian	ctor	MO NA	BAL	MMOR	£				1 ✓ Yes 2 ☐ No
	with th	Dire	10e. Street and Number	EET #2P		10f. Zip Code	~	10g.	Citizen of What Co	ountry?
	death ms 23	Funeral Director		2. Was Decedent Ever in U.		2121 /as Decedent of His	panic Origin? (Spe	cify Yes or No-	USA 14. Race - Ame	orican Indian,
920	filed within 72 hours after death with the Maryland Hygiene. Ather than "neturel", or Items 23e or 28a-1 show ant, the Medical Examinar must be notified at		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 KDNo If Yes, Give Year or Dates:	i	Yes, specify Cuban, Yes 2 No	Mexican, Puerto i Specify:	Rican, etc.)	Specify: Q1	e, etc. ACK
5-0	72 ho	eted	15. Decedent's Educi (Specify only highest grade	ation completed)	(Give I	ent's Usual Occupati	on ring most of worki	16b.	Kind of Business	
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Maryland	d be file	Be	17. Father's Name (First, Middle, Last) ELMER HAWIKINS					(First, Middle, Maid	en Sumame)	
ary	shouk ind Me s mark umatic	2	19a. Informant's Name/Relationship (Typ.	e, Print)	19b. Mailin			MERCER Route Number, Cit	y or Town, State, 2	Zip Code)
	and 2 ealth a m 27 ls		DENISE R. HAWKIN			ABINGTON	The second second	ALTO. MP		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel; or Items 23e or 28a-f show amportant: If item 27 is marked other than "neturel; or Items 23e or 28a-f show appring yor other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	lace of Dispos emetery, crem BUTUS	ition (Name of atory or other place)	09.16		LTO. MC	
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee	1	VA	Name and Address	of Facility REENE FL	WERAL SE	RVICE	
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ō	g Phys er this eral dii	n: To	27. Manner of Death	28a. Date of Injury	R/Outpatient 28b. Time of	3 DOA 28c. Injury a Work?	4 ursing Hon	e 5 Residence 8d. Describe how in		cify)
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	7		30. Name and address of person who corr	pleted cause of death (Item	Wedle	rint) wick RD	Cater	Juille. N	m 21.	228
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			For State	State of Maryland	d / Department of Health and	Mental Hygier	ne	
			1 - State Registrar		Certificate of Death	Reg.	2005	30125
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	how how	١.	10a. State 10b. County	10c. City	, Town or Location	0		10d. Inside City Limits
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	h th	<u>r</u>	10e. Street and Number		10f. Zip Code		Oltizen of What Col	untry?
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	deat ms	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S	5. 13. Was Decedent of Hispanic Origin? (5	Specify Yes or No-	14. Race - Amer	ncan Indian.
9	after pr. ft	Ī	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 No	If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White	e, etc.
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a	2 she and is m		19a. Informant's Name/Relationship (ype, Print)	19b. Mailing Address (Street and Number or Ri	ural Route Number, Cit	or Town, State, Z	ip Code)
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<u>ĕ</u>	Pa ant:		4 □ Donation 5 □ Other (Specify) MD	NATIONAL GEME 09.	-19-051	SHIPE!	MARWAIN
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licen	see . / . \ . 1.	22. Name and Address of Facility	ROWN JR.	Full Da	1 Hans
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/isl	I or Attendi after death. Director: A	II Ca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hom	ne, farm, street, factory, office	28f. Location (Street a	and Number or Pur	al Pouto Number
ā	al or afte I Dir d in t	Certification:	4 Homicide	building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	City or Town, Sta	te)	arriodie reamber,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by		29a. Certifier 1⊠ Certifying Phy	sician: To the best of my knowl	edge, death occurred at the time, date and place	and due to the cause/	s) and manner as s	tated
	ne Ho	Medical	one) 2 Medical Exam	ner. On the basis of examination and manner stated.	on and/or investigation, in my opinion, death occu	rred at the time, date ar	id place, and due to	the cause(s)
	withir To the	Ž	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month,	Day, Year)
			1 2 Sta	MD	RES 000	Sen		4 2005
	q		30. Name and address of person who c	empleted cause of death (Item 2	RES 000 13a) (Type, Print) new Mospital at Belt			
			Amena Ethe	ington Si	new Mospital at Belt	more		
1	Sta	te	31. Date filed (Month, Day, Year)	32: Registrar's Signatu	19 And D	-		
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DHMH 17 Rev 1/2001

Olivia Hamlett

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 28a-f per meo 284/9-19-05 vt. State of Maryland / Department of Health and Mental Hygien 0 5 AmendPi, perME, g863, 1/5/07 TT Certificate of Death 30126 Certificate of Death Reg. No. L. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Yeer Eric Paul Haynal Sept 13, 2005 /Medical unknown 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14909 Chelsea Circle Frederic Mt Airv
If Under 1 Year Fl#Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day,
March 7, 7. Age (In yrs. last birthday) **Funeral** 1**☆**M 2□ F Director 214-96-2485 36 Yrs. 1969 Germany Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ?7 is markad othar than "natural", or itams 23a or 28a-f ahow traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director MD Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 14909 Chelsea Circle 21771 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene.
Is marked other than "natural", or Ita 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No ģ Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Disabled N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any injury or other traumatic evant ORGE. Steven Haynal Nancy Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erika Haynal Wife 14909 Chelsea Circle Mt. Airy, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) St. Peter the Apostle 9/17/05 Libertytown, MD Church Cenetery ddress of Facility 21. Signature of Funeral Service Licenses Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Road Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Exsunguina /Medical Due to (or as a consequaice of) Examiner 1act vation Sequentially list conditions, I any, leading to inneclate cause. Enter Underlying Cause (Disease or injury Examine signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 Yes 1 Yes Hospital or Attanding Physician: funeral director, 25. Was case referred to medical examiner?
Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify)
Injury at 28d. Describes a how injury occurred Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? After 9-13-05 Year) 1 Natural 5 Pending unknown M self -inflicted 1 ☐ Yes 2 🛂No death. investigation 2 Accident filled in by the Director: 6 Could not be determined Suicide Aomicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) home 281. Location (Street and Nymber of Runel Route Number City or Town, State) 14909 Chelsea Cir. Mt. Airy, Md. within 24 hours after To tha Funeral Direc 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed n 31. Date filed (Month, Day, Year) Registrar's Signature State 1 6 2005 Registrar

LO	N HARP		1- For Unpend Item :	State of Maryland / C 23a-b&27 per me G	epartmen Certificat	t of Health and i 3-05 fas e of Death	Mental Hyg	iene 2005	30127
	Physici /Medic		1. Decedent's Name (First, Middle, Las	Harp			2. Date of Deat Month SEPT.	Day Year 11, 2005	3. Time of Death
	Examin	er	4a. Facility Name (If not institution, give UNIVERSITY HOSPI			Town, or Location of Deat LTIMORE CITY	1	4c. County of Opia	4
	Funeral Director		5. Social Security Number 218-21-8291 1 Usual Residence of Decedent	Charles 10	Yrs. If Under	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth Month, Day, June	Year 1988 M	thplace (State or Foreign ountry)
	a-f show	ctor	10a. State 10b. County	A 10c. City, Town	110	ore			10d. Inside City Limits 1 XYes 2 □ No
	h with the	ai Dire	10e. Street and Number 149 S. Carco	Ilton Ave.	10f. Zip	2/223	1	Og. Citizen of What Co	ountry?
36	72 hours after death with the Maryland naturel', or items 23a or 28a-f show disal Examiner must be motified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (X) No If Yes, Give Year or Dates:	13. Was Dece If Yes, spe	dent of Hispanic Origin? (Scriy Cuban, Mexican, Puerla 2000)	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
Maryland 21215-0036	within 72 hou lene. then "nature the Medical E	Completed by	15. Decedent's Ed (Specify only highest gra	de completed) College (1-4or 5+)	Decedent's Usu (Give kind of wo life. DO NOT u	ork done during most of wo	king	16b. Kind of Business	Andustry Public Col
land 2	uld be filed v Vental Hygie irked other I tic svsnt, II	To Be Co	17. Father's Name (First, Middle, Last) Frnest M	artina	Stua	18. Mother's Nar	ne (First, Middle, M	Maiden Sumame)	P
-	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hyglene. If item 27 is marked other then "natural", or items 23a or 28a-f show or other traumatic event, the Madigal Examinar must be notified at		19a. Informant's Name/Relationship (1) S. Cassan (2) 20a. Method of Disposition 1 Burial 2 Cremation 3	lra Harp 40 20b. Place of	Mailing Address Disposition (Natry, crematory or co	other place)	AveJ	Balto N 20c. Location - City or	11,21223
Baltimore	permit. Pages Department of I Important: If Its sny Injury or o		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen) [V]+	Name ar Joseph	nd Address of Facility	12005 Junesal	Lansdon Stonge, B.	une, Md. A.
0	Physician		23a. Part 1. Enter the disease, or come shock, or heart fature. List only Immediate Cause (Final disease or condition resulting in death)	plications that aused the death. Do rone cause on each line. Pulmonary throm			or respiratory arre	sst,	Approximate Interval Between Onset and Death
8760,	Medical Examine and spring the purial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Deep venous thro Due to (or as a consequence of the consequence of	ombosis of):				
.O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ⊟Ectopic p 5 ⊟ Other (s _k			23d. Date of de Month	livery Day Year
<u> </u>	sign d be	ρ	Part II. Other significant conditions of	ontributing to death but not resulting in	n the underlying o	cause given in Part I.		oacco use contribute to	o the cause of death?
Vital Records,	The ate h	Completed					24a. Was ar autops perform Yes 2	y prior to	utopsy findings available completion of cause of 2 No
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case relerred to medical examiner? 1 □XYes 2 □ No	Hospital: 1 ☐ Inpatient 2X ER/Ou	stantiant 3 D	Othor	ath (Check only on		
of	ding After fune	ation: To	27. Magner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. 1		28c. Injury at Work? 1 Yes 2 No	28d. Describe ho	nce 6 Other (Spe w injury occurred	cny
Division	or A lifter Direct in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, lactor	y, office	28l. Location (St. City or Town	reet and Number or R. , State)	ural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai		ysician: To the best of my knowledge niner: On the basis of examination an and manner stated.					
	To th withir To th comp	Me	29b. Signature and title of certifier	10 e - 2 11 10	29	c. License number O.C.M.E	29	SEPT. 12,	
			Joshy J 30. Name and address of person who Tasha Zareen			EET, BALTIMO	RE,MARYLA		
	Sta Registi		31. Date liled (Month, Day, Year) SEP 1 6 20	32 Registrar's Signature					

.1101	ton HTT	. Д	1 - For State Registrar	State of Maryland / D		artment rtificate			and M		giene	$\leq U \cup U$)5	30	128
			1. Decedent's Name (First, Middle, La	st)						2. Date of Dea	_		V	3. Time	of Death
	Physici /Medio		SOTHORON EDWARD H	ILL						Septemb	oer	13 ,	2005	15:	37 P ^M
	Examir	ner	4a. Facility Name (If not institution, giv			4b. City, T	own, or	Location of	of Death			. County			
			Good SAMARITAN Ho 5. Social Security Number 6.5	spital	h ./ \	Balt:		e If Under	24 Hrs			altı		City	
	Funeral Director		218-58-6038	lex 7. Age (In yrs. last birti M 2□F 53	nday) rs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Date of Cot. 2)	h V. Year)	951	9. Birthp	ace (State try)	or Foreign Mass.
			Usual Residence of Decedent							000. 2	0, 1	1001	003	0011,	11035.
	how phow	_	10a. State 10b. County	10c. City, Town	or Lo			- C-	L.,				10	Od. Inside (
	Ba-f	cto	Maryland Baltimor	e city				e Ci	су 						s 2 No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "naturel", or Items 23a or 28a-f ehow or other treumatic event, the Medical Examination must be coulfied at	Completed by Funeral Director	10e. Street and Number 5860 Belair Rd.			10f. Zip (Code	2120	6		10g. Cit	tizen of W US	/hat Coun A	try?	
	er dez	nuel	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Was Decede f Yes, speci	nt of Hi	spanic Ori	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)			- Americ		
36	rs afte	y F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes XX No If Yes, Give Year or Dates:		I□Yes 2		Specify:				Specify:		ite	
8	2 hou	pa	15. Decedent's Ed	ducation 16a.	Deced	lent's Usual	Оссира	tion			16b. K	ind of Bu	siness/Ind	ustry	
215	hin 7;	pie	(Specify only highest gra	College (1, 4or 5.)	(Give life. (kind of work DO NOT use	done d retired)	uring mosi	of worki						
2	filed wit Hygien sther the	Son	9th grade (0-12)	CN/9A (1-4or 5+) Lal	bor	er					Roof	ing	Indu	stry	
land	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, the Ms	To Be	17. Father's Name (First, Middle, Last, Unknown						r's Name) (First, Middle, ☐	Maiden	Sumam	e)		
Maryland 21215-0036	d 2 should it and Men It and Men It is marke treumatic		19a. Informant's Name/Relationship (A Route Numbe					
ē,	s 1 and 2 f Health item 27 l		20a. Method of Disposition	20b. Place of	Dispos		of	1		Date			City or To		·
E G	Part Tr		1 □ Burial 答	Indinovalition State Motro	Ċre	mator	/ In	c, 9-	-15-(05	Bal	.timo	re, N	٩d.	
Baltimore,	permit. Pages 1 and 3 Department of Heatth Importent; if item 27 any injury or other tr. 2002.		21. Signature of Funeral Office Licer	866						ssahn F ltimore					
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do no	ot ente	er the mode	of dying	, such as	cardiac c	r respiratory ari	rest.			Approxima Interval Be	ate
	Physician		Immediate Cause (Final disease or condition	a COMPLICATION	^	~ -		11/=2	, ,	IRRHA	- 5 / 1	C		Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence or		_OF	- 1-00	LVCK		1 KIZICE	2.3/	7		-	
	Examine	_	Sequentially list conditions,	b											
٠,١	led isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a consequence of	17:										
10	axecular and al-trar	хаг	that initiated events resulting in death) Last	c. Due to (or as a consequence of	f):							_	-		-
8760r/2	cate be executed physicien and the burial-transit	dical		d.											
68	tificat ng ph) as th														7700
Вох	death certific attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death	3□	Ectopic pre	nancv				1		of deliver	-	
0.	at the dea by the at tached fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown		Other (spe						Mon	th I	Day	Year
٩.	that the ed by detac			ontributing to death but not resulting in	the un	derivino ca	ISA QIVA	n in Part I		23e. Did to	bacco u	ise contri	bute to the	e cause of	death?
of Vital Records,	sign sign	ed by												bly 4 🔀	
ဝင္ပ	iaw requ es been 2 should	Completed								24a. Was a		24b. W	ere autop	sy findings	available
<u> </u>	The ete h page	E O							_	autops perfor		de	ath?	pletion of	cause or
/ita	ician: certific ector,	Be	25. Was case referred to medical examiner?				1 -		of Death	Check only or					
_	this al dia	ဥ	1 Yes 2 No 27. Vanner of Death	Hospital: 1 Inpatient 2 X ER/Outs			Other	4 🗀 Nur		ne 5□Reside					
	e je	tlon	1 Natural 5 ☐ Pending		me of jury	м 28	Work	at ? es 2.∐.N		8d. Describe h	ow injur	y occurre	d		
Division	Attending ir death. ector: Aflei by the fune	fica	3 Suicide 6 Could not be		m, stre			63 2		8f. Location (S	treet and	d Numbe	r or Rural	Route Nur	nher
Ŕ	2 4 4 5	Certification;	4 Homicide determined	building, etc. (Specify)			J.1100			City or Town	n, State,)	07 710721	10010 742/	,,
	noc.	Medical C	29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledge, ilner: On the basis of examination and and manner stated.	death /or inv	occurred at estigation, i	the time	o, date and nion, deat	place, a	and due to the co	ause(s) ate and	and man place, ar	ner as sta	ted. the cause(s)
	To the Howithin 24 has To the Fur completely	Me	29b. Signature and title of certifier			29c.	icense	number		2	9d. Date	e signed	(Month, D	ay, Year)	
)) (mas	2		0.0	.M.	₫.		0	9-14	4-200)5		
	1		_	completed cause of death (Item 23a) (T	Гуре, Е	Print)									
	,	, /			nn	Stree	t, 1	Balti	more	, Maryl	and	2120)1		
2	Sta Registr		SEP 1 6 20	32 Flegistrar's Signature	lan.	all s									

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of Marylar		nt of Health and te of Death		iene 005 30129
Physic /Medi Exami	cal	Decedent's Name (First, Middle, Lase	IN E. F	HELPU	O/CZ	2. Date of Death Month	
Funeral Director	iei	5. Social Security Number 6. S 	PARISS HOSP	last birthday) Yrs.	er 1 Year It Under 24 Hrs Days Hours Min		PORTIMORE CO 9. Birthplace (State or Foreign Country) 7.
the Maryland 28a-f show	rector	Usual Residence of Decedent 10a. State 10b. County 10e. Street and Number	4 B	10111	RE ip Code	10	10d. Inside City Limits 1 Deres 2 □ No
15-0U36 72 hours after death with the Maryland 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show colical Examiner must be notifiled at	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 Pes 2 ONo	J.S. 13. Was Dec	2/224 edent of Hispanic Origin? (secify Cuban, Mexican, Puer 2/2/No Specify:		14. Race - American Indian, Black, White, etc.
ithin 72	Completed by	3 Widowed 4 Divorced 15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)	If Yes, Give Year or Dates: lucation de completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of w life. DO NOT	ual Occupation rork done during most of wo use retired)		Specify: W/F; TE 16b. Kind of Business/Industry DISABLED
iand 2	To Be Co	17. Father's Name (First, Middle, Last) STAID SWADS	HELOWI'	100000000000000000000000000000000000000		me (First, Middle, N	
S 1 and 1 tem 2 tem 2		19a. Informant's Name/Relationship (STANLEY HELL 20a. Method of Disposition 1 Burial 2 Cremation 3 D	OWICZ 20b.	Place of Disposition (N cemetery, crematory of	NSFIELD N	D BA	City of Your, State, 21) Code)
Battimore, permit. Pages 1 a Department of Hee Important: If item any Injury or othe		' 4 □ Donation 5 □ Other (Specification of Specification of Superior Specification of Spec	See Buda &	· SKa	and Address Facility	2005 1: 2829 HL 3140, 1	DACTO MP.
Physician /Medical	DOTE	23a. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. a. LUNG CANCE Due to (or as a consec	R	ode of dying, such as cardia	c or respiratory arre	st, Approximate Interval Between Onset and Death
be executed sicien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diesase of Injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect.	quence of):			
The cords, P.O. box 68/60, The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 □Ectopic			23d. Date of delivery Month Day Year
ecords, P. law requires that the same signed by as been signed by 2 should be detacted.	by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the underlying	cause given in Part I.		acco use contribute to the cause of death? s 2 \(\text{No} \) No 3 \(\text{Probably} \) Probably 4 \(\frac{\pi}{N} \text{Unknown} \)
	S Completed	25. Was case referred to medical			26 Plans of Do	24a. Was ar autopsy perform 1 Yes 2	prior to completion of cause of death? No 1 Yes 2 No
n of ng Phys	ation: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 [100		nce 6 NOther (Specify) HOSPICE
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building, etc. (Speci	ify)		City or Town,	
he Hos. in 24 ho he Fund pletely f	Medicai	(Check only 2 Medical Examone)	ysician: To the best of my kn niner: On the basis of examin and manner stated.	ation and/or investigation	on, in my opinion, death occ	urred at the time, da	te and place, and due to the cause(s)
With To the common of the comm	×	29b. Signature and title of certifier		2	9c. License number D43725		d. Date signed (Month, Day, Year) 9/12/05
	ate	30. Name and address of person who DR. TARIQ MAHMOO 31. Date filed (Month, Day, Year)	D 2300 dulan	ey valley	d. timonium	, md 2109	3
Regist		31. Date filed (Month, Day, Year) SEP 1 6 200	5 Alexander A	& Cools			

DHMH 17 Rev 1/2001

SEPTEMBER 11, 2005 4:50 a.m.

MELVIN HELOWICZ

1 - For State Registrar	State of Maryland	/ Department of Health and Certificate of Death	Mental Hygiene	2003 3013
1. Decedent's Name (First, Middentification) /Medical 4e. Facility Name (If not institution)	darris	4b. City, Town, or Location of Dea	2. Date of Death Month Day September th 4c	y Year 3. Time of Death
Funeral Director 5. Social Security Number 6. Facility Name (if not institution in the instit	6. Sex 7. Age (In yrs. las	I Center Baltimor	8. Date of Birth	Birthplace (State or Forei Qountry)
10a. State 10b. Count		Town or Location ACRAMENTO		10d. Inside City Limi 1 ☐ Yes 2 ☑ N
10a. State 10b. Count of the part of the p	If Yes, Give	. 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	2	14. Rece - American Indian, Black, White, etc. Specify: BLACK
15. Decede (Specify only high light	ent's Education est grade completed) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) ASSOCIATE ANA	orking	CIND OF Business/Industry
17. Father's Name (First, Middle Legal Land Land Land Land Land Land Land Land	MULLEN		OLLY W	
*4 Donation 5 Other 21. Signature of Funeral Service 23a. Part1. Enter the disease, shock, or heart failure. Limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. Enter Underlying cause. Enter Underlying cause. Enter Underlying cause to cause or injury that initiated events resulting in death) Last	kulu Grune	ence of):) BAUTIMON	TLAND, MARY LAN WEENE FUNERAL RE, MD 2-12-12 Approximate Interval Between Onset and Death 10 day
of the attending of th	d. 23c. If yes, outcome of pregnan 1	death 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
spond ped by A Derted by A Der	tions contributing to death but not resul	lting in the underlying cause given in Part I.	1 ☐ Yes 2	use contribute to the cause of death of of
5 0 25. Was case referred to medi	cal	26. Place of D	performed?. 1 Yes 2 No eath (Check only one)	death? 1 ☐ Yes 2 ☐ No
Yes 2 No	28a. Date of Injury	## 28b. Time of Injury M	Home 5 Residence 28d. Describe how inju	
3 ☐ Suicide 6 ☐ Cou	id not be armined 28e. Place of Injury - At hor building, etc. (Specify)	me, farm, street, factory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, re)
A Homicide 4 Homicide	ying Physician: To the best of my know al Examiner: On the basis of examinati and manner stated.	wledge, death occurred at the time, date and pla ion and/or investigation, in my opinion, death oc	ce, and due to the cause(sourred at the time, date an	s) and manner as stated. nd place, and due to the cause(s)
	flier M D on who completed cause of death (Item	29c. License number RES - 00 23a) (Type, Print) 5 Hen Avenue Baltin		ate signed (Month, Day, Year) Otember 11, 2003
(0) 1 1 211 4 6	A I A I	1	110	21

State of Maryland / Department of Health and Mental Hygier 0.0530131 1 - For Stete Registre Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 12:55 P M Hines SEPTEMBER 9 , 2005 Jennie R. /Medical 4b City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hospinal SIMAI BALTIMORE BALTIMORE CITY OF If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Days Hours Yrs. 83 Director 230-20-6393 VA 11 05 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits rthan "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at 1X Yes 2 No Baltimore Director MD NA 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 3908 Ridgewood Ave U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1☐ Yes 2√ No Specify. Specify: 3 Nidowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Factory 11th grade na marked other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked othe any lighty or other traumatic event 2008. 18. Mother's Name (First, Middle, Maiden Sumame) Bertha Scales Lynn Penn 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2654 Melba Ellicott City, Md 21042 Daisy Jackson-Daughter Road, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ▼ Yurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Park 9/15/05 Randallstown, 21. Signature of Fyeral Service Licenses 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 23a. Part. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or n-art failure. List only one cause of each line. 21215 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ENTRILLIAR FIBRILLATION /Medical (or as a consequence of): IABETES Examiner CarplicaTions OF 72925 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last Due to (or as a consequence of) Examine physician end the burial-transit Due to (or as a consequence of): 68760. Physician/Medical attending pl IF FEMALE: Box 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. certificete has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, MELLITUR 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 2 No 1 ☐ Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner: Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient Certification: To 3 DOA 27. Manner of Death 28b. Time of Injury 28c. Injury al Work? 28d. Describe how injury occurred or Attending 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funerel D completely filled it 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To tha 29c. License number 29b. Signature and title of certific D0061529 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) SINA LOGITAL OF GOLDSIEIN 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

SEP 1 6 2005

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		State of Maryland / Department of Health a 1 - State Registrar Certificate of Death	and Mental Hyg	ien2005 30132
		Decedent's Name (First, Middle, Last)	2. Date of Dea	th 3. Time of Death
Physic		Douglas Eugene Haines	Month	Day Year 2:40 A M
/Med Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location o		4c. County of Death
	87 Q	Gilchrist Center Towson		Baltimore Co.
Funera	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	24 Hrs. 8. Date of Birth Min. (Month, Day	9. Birthplace (State or Foreign
Director		216-66-1530 1\(\overline{\text{Y}} \text{M} 2 \subseteq F 49 \text{Yrs.} \text{Months Days Hours} \text{Pours}	Dec. 31	
D *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d Inside City Livers
anyla anyla	2			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
See to See	Director	Maryland Baltimore Dunda 10e. Street and Number 10f Zin Code		
27 18 2005 0340 A death with the Maryland me 23a or 28a-1 show travet be notified at	2			0g. Citizen of What Country?
O O O O O O O O O O O O O O O O O O O	Funeral	8510 Sandy Plains Road 21222 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Control Ori		United States 14. Race - American Indian,
Se le de la le de la le le de la le	Ę.	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2☑ Married 1 □ Yes 2 ☑ No	, Puerto Rican, etc.)	Black, White, etc.
336 III. or	by F	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: White
21215-0036 d within 72 hours after dea giene. The "natural, or Iteme to the "hadical Examination."	Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/Industry
215 215 7 nin 7	ple	(Specify only highest grade completed) (Give kind of work done during most life. DO NOT use retired) (Give kind of work done during most life. DO NOT use retired)	of working	
d wit	E O	12 Years Warehouse Worker	/Driver	Terminal Corp.
and 2 and 2 and 2 and 1 kg and	Be	17. Father's Name (First, Middle, Last) 18. Mother	r's Name (First, Middle, i	Maiden Surname)
Baltimore, Maryland 21215-0036 0340 A permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. If them 27 is marked other than "natural", or iteme 23a or 28a-1 show any Injury or other traumatic avant, the Medical Examinat must be notified as any once.	2	Raymond Haines	Gladys Smith	1
and and		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number		
and and m27		Mrs. Kathleen Haines (Wife) 8510 Sandy Plains	CC-20 / C	dalk, Maryland 21222
or of H		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State	Date	20c. Location - City or Town, State
Baltiment Pag Department Importent: Importent: Importent: 0 any Injury or 000s.		Oak Lawn Cemetery 9/16/	/2005	Baltimore, Maryland
Balt Permit Depart Import any inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda—Ruck Funer	al Home of	Dundalk, Inc.
m «a==a	(0.1)	7922 Wise Ave.	Dundalk, M	Maryland 21222
**	3	23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a snock, or heart failure. List only one cause on each line.	cardiac or respiratory arm	Interval Between
Physician		Immediate Cause (Final disease or condition and instance of the Cancer United Instances of th	Nenown pl	Umany (months
/Medical Examiner		resulting in death) Due to (or as a consequence of):	-	7
Lammer		Esquentially list conditions,		
1 P6 15	Examiner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
and I-tran	хап	that initiated events c. resulting in death) Last Due to (or as a consequence of):		
58760, cicate be executed physician and site burial-transit		223.10 (0. 40 2 30.135430133 37).		
\$87 scate	dlcal	d		
Box 6 leath certific	by Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		22d Date of delivery
Box eath cert attendin	clan	in the past 12 months?		23d. Date of delivery Month Day Year
P.O. BOX that the death cered by the attending detached for use	lysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		
S, P.(es that the	P.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	pacco use contribute to the cause of death?
ds, uires v signe			1 □ Ye	es 2 No 3 Probably 4 Anknown
Cord w require been si	Completed		24a. Was a	
II Rec	d L		autops perfor	y prior to completion of cause of death?
of Vital Records, P.O. Box 6 Physician: The law requires that the death certificate has been signed by the attending ral director, page 2 should be detached for use as	ပိ	25. Was case referred to medical 26. Place		1 Yes 2 No
f Vita yslclan: is certific director,	00	examiner?	of Death (Check only on	
Division of Vital Records, to attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be continued.	To:	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	rsing Home 5 Reside	ow injury occurred
Vision Attending r death. ector: After	tlor	1) → Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ N		,-,
/isio	flea	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (St	reet and Number or Rural Route Number,
Div.	Certification:	4 ☐ Homicide determined building, etc. (Specify)	City or Town	n, State)
Division To the Hospitel or Attent within 24 hours after deatt To the Funerel Director: completaly filled in by the		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and	d place, and due to the ca	ause(s) and manner as stated.
tha Ho nin 24 t the Fu npletaly	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deat and manner stated.	h occurred at the time, d	ate and place, and due to the cause(s)
To the within To the comp	ž	29b. Signature and file of certifier 29c. License number		9d. Date signed (Month, Day, Year)
		D5830	3	September 13 2005
15		30. Name and address of person who completed cause of death (Item 23a) (Type-Print) MICH CLOCKS MO 6601 N. CLOCKS ST 72		
			no no	erect.
3. J .	tate	31. Date filed (Month, Day, Year) SEP 1 6 2005		
Regis	trar	SEP 1 6 2005 Steere S. Agreet		

			riease	State of Maryland /		ealth and Mental H	_	00100
		1	For State Registrer	Oldio of Maryland	Certificate of L		Reg. No.	30133
			1. Decedent's Name (First, Middle, La	ist)		2. Date of D Month	Death Day Yeer	3. Time of Death
	Physicia /Medic	al -	Suarifa	Hargrou		9	15 05	12.35 AM
1	Examin	ΨI	4a. Facility Name (If not institution, gir		- 0 0	Location of Death	4c. County of Dear	ın
	Funeral			Sex 7. Age (In yrs. last I		If Under 24 Hrs. 8. Date of B Hours Min. (Month, L		thplace (State or Foreign
	Director		412.70-1646	1 M 2 SYF 77	Yrs.	3-8-	-1928 Ma	ryland
	land ow	- H	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location			10d. Inside City Limits
	Mary e-feh	ctor	led N/A	· Bal	timore			1 Yes 2 No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Menlat Hygiene. If item 27 is marked other than "natural; or items 23a or 28e-f ehow or other treumatic event, it is Marulcal Exama ar must be notified at or other treumatic event, it is Marulcal Exama ar must be notified at	by Funeral Director	10e. Street and Number	CL	10f. Zip Code 212	18	10g. Citizen of What Co	ountry?
	ns 23	eral	3/5 E 28 T	12. Was Decedent Ever in U.S.		spanic Origin? (Specify Yes or No., Mexican, Puerto Rican, etc.)	No- 14. Race - Ame Black, Whit	
ာ့	after or item	/ Fur	1 Never Married 2 Married	If Yes Give	1 ☐ Yes 2 ☐ No	Specify:	Specify: R	ack
21215-0036	hours turei',	ed b	3 Widowed 4 Divorced	Year or Dates:	6a. Decedent's Usual Occupa	ation	16b. Kind of Business	
215	within 72 ene. than "ne he Madic	Completed	(Specify only highest gi		(Give kind of work done of life. DO NOT use retired	luring most of working)	0 66	. 10
	filed with Hygiene. Ither ther	Con	17. Father's Name (First, Middle, Las	21)	4id	18. Mother's Name (First, Midd		rla
lanc	ould be fi Mental I- arked ot atic ever	To Be	Truis K.	Lindsav		11	rter	
Maryland	and Miss mari	_	19a. Informant's Name/Relationship			and Number or Rural Route Num		Zip Code)
	fealth fealth om 27 i		Oloria Kichar 20a, Method of Disposition	100 H Con 1101 -	315 E. 26 H	Date Date	20c. Location - City or	Town, State
nore	ages 1 nt of H t: If ite		1 Surial 2 □ Cremation 3 1 Donation 5 □ Other (Spec	Removal from State	etery, crematory or other place	() (C) of 22 2	Kill 6	-1.
Baltimore,	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Lice	1-1109	22. Name and Address	ss Facility (Flore	Service	PA
ä	Deparent Important in processions of the procession in pro		Carlton C.	Wanfare	1701 Mc Cul	Joh St. Balk	1. hd. 2/2	n
			shock, or heart failure. List onl	mplications hat caused the death. Drug one cause on each line.				Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequent	due to A	anetobacter !	baumqoaii _	
ч	Examiner		Sequentially list conditions	b		wan Auganile	Hods)	7 days
	Bit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	ce of):			0
8	e be executed sicien and e burial-transit	Examiner	that initiated events resulting in death) Last	c	ce of):			
160	0 8 0	cal		d				
.89	eath certificate attending phys	by Physician/Medi	IF FEMALE:	23c. If yes, outcome of pregnancy			00 d D-1(d-	
Вох	attend for us	cian/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal dead	ath 3 ☐Ectopic pregnancy		23d. Date of de Month	Day Year
0	that the de led by the a detached	hysi	1 ☐ Yes 2 K No 9 ☐ Unknown	9□ Unknown				
S, P	Se D0		Part II. Other significant conditions	s contributing to death but not resulting	ig in the underlying cause give		id tobacco use contribute t □ Yes (2/21No 3 □ P	o the cause of death?
ord	v require been sig should b	eted				24a. W		utopsy findings available
Vital Records,	The law	Completed				au	utopsy prior to death?	completion of cause of
ital	ician: Th certificate rector, pag	Be Co	25. Was case referred to medical			26. Place of Death (Check onl		
	Physicie this cert al direct	은	examiner? 1 Yes 2 No	10.00	/Outpatient 3 DOA Oth	4 Nulsing Home 3 He	esidence 6 Other (Spe	ecify)
on o	ign Ter ner	tion	27. Manner of Death Natural 5 Pending Accident investigat	(Month, Day Year)	Injury Wor	k? Yes 2 □ No	to now injury occurred	
Division of	Attendi er death. ector: A by the fu	Certification:	3 Suicide 6 Could not	be 380 Bloom of lower At home	a, farm, street, factory, office		n (Street and Number or R Town, State)	Rural Route Number,
ō	itel or urs afte rel Dir lled in							
	Hosp 24 hou Fune stely fi	Medical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best of my knowle aminer: On the basis of examination and manner stated.	idge, death occurred at the tir i and/or investigation, in my o	ne, date and place, and due to to pinion, death occurred at the time	ne cause(s) and manner a ne, date and place, and du	e to the cause(s)
	To the Hospitel or Attendir within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Me	29b. Signature and title of certifier		29c. Licens		29d. Date signed (Mon	
	1		chagain	HD.	RES	'- 000	Sep 15 m	12.50 AM
	5	1	V .	completed cause of death (Item 23	Ba) (Type, Print)	'- GOO HOSPITAL	OF RAIT	IMARE.
	St	atė	31. Date filed (Month, Day, Year)	32 Registrar's Signature	MD, SINIAI	_1705 P.11 AT	0 - 011	TITUING
	Regist	rar	SEP 1 6 20	JUD Roman M.	Snack !			

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Yanew Lovern as Hargnove, I wanted

State of Maryland / Department of Health and Mental Hygiene 2005 30134 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** SEPT. 2005 14 3:55 PM LYNNETTE NICOLE JOHNSON

4a. Facility Name (If not institution, give street and number) /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** RANDALLSTOWN BALTIMORE GENESIS HEALTHCARE RANDALLSTOWN Birthplace (State or Foreign Country) If Unde 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 1 ☐ M 2 💢 F 35 216-82-8928 07/01/1970 MARYLAND Director Usual Residence of Decedent with the Maryland 10c. City Town or Location 10d Inside City Limits 10h Count 10a State or 28e-f show must be notified at 1 ☐ Yes 2 📆 No PIKESVILLE MD BALTIMORE Direct 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number 21208 4803 HAWKSBURY ROAD USA 230 Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Race - American Indian, Black, White, etc. tems Never Married 2☐ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2X No Specify: Specify: BLACK If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced "neturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) than " College (1-4or 5+) Elementary/Secondary (0-12) DISABLED DISABLED 12TH other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be is marked of JOSEPH PENDER PEGGY JOHNSON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) if Health item 27 i PEGGY JOHNSON / MOTHER 4803 HAWKSBURY RD, PIKESVILLE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X Burial 2 □ Cremation 3 □ Removal from State permit. Pages Department of Important: If it any injury or o ZION CEM. 0/21/05 BALTIMORE CO., MD Donation 5 Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD nter the disease, or complications that caused in high failure. List only one cause on each Approximate
Interval Between
Onset and Death
I - 2 YEARS. he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immedia Cause (Final dises or condition resuling in death) END STAGE ALDS. Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physicien; The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): iding physician Box 68760, Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. | the a 9 Unknown cate has been signed by , page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To this Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 9/15/01 DOO 60878 RANIDALLS who completed cause of death (Item 23a) (Type, Print) 30. Name and address LIBERTY ROAD NIVEDNA BANSAL

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygie 20 0 5 30135 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day Year **Physician** JOHNSON ADA12:08 A N HONDER 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOU OhNS TIMORC If Under 1 Year | If Under 24 Hrs. 7. Age 5. Social Security Number (In yrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M X X Director 218**-**42**-**2344 14 MI death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1X Yes 2 □ No Baltimore Director MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 U.S.A. Funeral 6802 Eastridge Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural; or ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government Defense Commercial Artist 2yrs 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Miles George Wise 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6802 Eastridge Road, Baltimore, Md 21207 Kenneth Johnson-Husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) permit. Pages Department of Important: If it any injury or c 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet.9/19/05 Owings Mills, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sovice Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enjor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER PANCREATIC **Physician** MONTHS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infilted active. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner The law requires that the death certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an certificate has b lirector, page 2 s autopsy performy 1 ☐ Yes 2 ☐ No 1 Yes 2 XNo Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 ☐ Yes 2 XNo this 28a. Date of Injury (Month, Day Year) Director: After the in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Davilhim, M.D. RES-000 JEPTEMBER 13,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 NORTH WOLFE STREET BALTIMORE MD 21287 JOHNS HOPKINS HOSPITAL DAVID LIM 31. Date filed (Month, Day, Year) SEP 1 6 2005 32. Registrar's Signature State Registrar

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			1 - State of Maryla State of Maryla	nd / D	epartment of F Certificate of I	lealth a Death	nd Mental H	ygiene ()5	30136
	Physici	an	1 Decedent's Name (First Middle Last)	< iNO			2. Date of E	Death Day	Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)	21100	4b. City, Town, o	r Location of	Death	4c. Coun	2005 ty of Death	9 1 M
			GENEGIS HEALTHCARE CATE	INSVI	LE CATON	Svine	MO.		ALTO.	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs		rs. If Under 1 Year Days	Hours	Min. 8. Date of E (Month, L 03 · 08	Day, Year)	9. Birthp Coun	lace (State or Foreign itry) MD
	land wc		Usual Residence of Decedent 10a. State 10b. County 10c. C	City, Town	or Location				1	0d. Inside City Limits
	e-f she	ctor	MD BALTIMORE C	MON	ISVILLE					1 ☐ Yes 2 🖸 No
	with the	Dire	10e. Street and Number		10f. Zip Code	20		10g. Citizen of		itry?
	death ms 23 r must	Funeral Director	4 MCINTOSH COURT 11. Marital Status 12. Was Decedent Ever in	U.S.	2122 13. Was Decedent of H	ispanic Origi	in? (Specify Yes or N	lo- 14. Ra	USA ace - Americ	
36	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other then "neturel", or Items 23e or 28e-1 show marked other then "neturel", or Items 23e or 28e-1 show marked other than Madical Examinar must be routhed at	by Fu	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	Puerto Hican, etc.)	Spec	ack, White,	
900	72 hour	ted t	15. Decedent's Education (Specify only highest grade completed)	16a. E	Decedent's Usual Occup	ation	-6	16b. Kind of I	Business/Inc	
21215-0036	within 7 ene. then "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		Give kind of work done of life. DO NOT use retired LABORER	during most (or working	CONST	PILCT	IOAl
	should be filed wand Mental Hygiers amarked other tiving umatic event, In	Be Co	17. Father's Name (First, Middle, Last)		LHOULER	18. Mother	s Name (First, Middl			1014
Maryland	d Menta d Menta narked	To	WILLIAM KING	1		Suzi				
	d 2 th au		19a. Informant's Name/Relationship (Type, Print) DIANE KING (WIFE)		Mailing Address (Street : MCINTOSH		CATONSV			228
altimore,	permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tro		20a. Method of Disposition 20b. 1 105 -Burial 2 Cremation 3 Removal from State	Place of D	Disposition (Name of crematory or other place		Date	20c. Location	- City or To	wn, State
<u>=</u>	artment artment ortant: injury		* 4 □Donation 5 □Other (Specify) 21. Signatity e of Funeral Service Licensee ▶	ESTL	AWN		9.14.05			LE, MD
Ba	Depared Important any ire		Daughn I		VAUGHN C. 5151 BALTO.	GREE!	NE FUNER PIKE BA	LAL SER LTO. MO	VICE 2122	9
			23a. Part1. Enter the disease, or complications that caused the dec shock, or heart failure. List only one cause on each line.	ath. Do no						Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a conse	auence fi): ·					months
	Examiner	_	Sequentially list conditions, b.							
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	quence of):					
Ö,	icate be executed physician and s the burial-transit		resulting in death) Last C. Due to (or as a conse	quence of):					
88760		edical	d							
Box	leath certific attending p		IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fel		3 □Ectopic pregnancy				ate of delive	•
o.	The law requires that the death certif tle has been signed by the attending tage 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		5 ☐ Other (specify)			М	lonth	Day Year
ά, σ	res that i igned by be deta	by Ph	Part II. Other significant conditions contributing to death but not re	sulting in t	he underlying cause give	en in Part I.	23e. Did	tobacco use cor	ntribute to th	e cause of death?
ord	w require been sig should b						1	Yes 2□No	3 Proba	ably 4 Whiknown
Rec	he law e has b age 2 s	Completed					peri	opsy ormed?	prior to con death?	sy findings available apletion of cause of
ıtal		Be C	25. Was case referred to medical examiner?			26. Place o	1 ☐ Yes		1 🗆 Yes	2 ∐ No
ot v	Physic r this corral dire	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ 27. Manner of Death 28a. Date of Injury	ER/Outp		4 Nurs	ing Home 5 Res	how injury occu)
lon	Attending P death. ctor: After t y the funera	ation	1 Patural 5 Pending (Month, Day Year) 2 Accident investigation	Inju	ury Work	k? Yes 2 □ No		Tiow injury occo		
Division of Vital Records,	l or Atte after de Directo in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spec	home, farn	n, street, factory, office		28f. Location City or To	(Street and Num own, State)	ber or Rural	Route Number,
	To the Hospital or Attending Physician: within 24 hours alter death. To the Funciel Director: After this certific completely filled in by the funeral director,		29a. Certifier (Check only 2 Medical Examiner: On the basis of examiners	nowledge,	death occurred at the tim	ne, date and	place, and due to the	cause(s) and m	anner as sta	ated.
	o the hithin 24 o the formplete	Medical	one) and manner stated. 29b. Signatore and title of certifier	en	29c. License			29d. Date signe		
	4		· Blyce the	M	b D3	696	+2	Seft	13, 7	2005
A	(n)		30. Name and address of person who completed cause of death (Ite	m 23a) (T	ype, Print) Vedeni4	RD.	Cators	stle.	~ C	4228
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Sign		pertil					
	Registr	ar	ALL TO FOOD AND SO	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0.0530137 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Anthony Stanley Kedzior 8:45 P M <u>September 12. 2005</u> /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9907 Marilynn Road Baltimore Perry Hall If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 1 XM 2 ☐ F 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 219-32-7630 71 Director Dec. 7. 1933 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Medical Examins: must be notified at 1 Yes 2 No MD Baltimore Perry Hall Direct 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9907 Marilynn Rd. 21128 U.S.A. fited within 72 hours after death v Hygiene. Funerai t2. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. White ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygient Important: if item 27 is marked other that any injury or other traumation. Consultant Home Improvement Ctr. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anthony Kedzior Lottie Pacanowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3720 Timahoe Circle, Baltimore, Maryland 21236 Beth Kedzior 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Joseph Cemetery 9/16/2005 Baltimore, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 0 9705 Belair Road, Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEPATO CELLULAR **Physician** /Medical Examiner Saqua titly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical 23d. Date of delivery Month Year Day se contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

Certification; To Be Completed

Medicai

After this certificate has Director: After this certification by the funeral director, filled in by To the Funeral

25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	patient 3□ DOA	26. Place of Death Other:	(Check only one) e 5 x Residence
OF Man and advantage marriage				
				24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
Part II. Other significant conditions	s contributing to death but not resulting in	the underlying cau	se given in Part I.	23e. Did tobacco u 1 ☐ Yes 2
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic preg 5 ☐ Other (speci		

1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certifier

29c. License number D16354

29d. Date signed (Month, Day, Year) SEPTEMBER 14, 2005

☐Other (Specify) occurred

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CATON AVE. BALTIMORE MD 2/229

State Registrar 31. Date filed (Month, Day, Year) SEP 1 6 2005

DLE



		1 - For Stata Registrar	State of Mary	land / Depa	artment of I	Health and Death		ene 0 0 5	30138
Physic /Med	cal	Decedent's Name (First, Middle, Las Aa. Facility Name (If not institution, give	Marie	104	hlev	r I continue of Door	2. Date of Death Month	Day Yeer	22 25 SW
Exami		5. Social Security Number 6. Se	Nursing	Center	If Under 1 Year	or Location of Deat	re	4c. County of De	
Funeral Director			M 20XF 9	yrs. last birthday) 7 Yrs.	Months Days	Hours Min.	(Month, Day,		nthplace (State or Foreign Country) aryland
Maryland -f ehow	tor	10a. State 10b. County N/		c. City, Town or Lo	cation 11timore				10d. Inside City Limits 1 ∑ Yes 2 ☐ No
th the or 28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	Country?
23a d	rai	1226 Leeds Terrac	e		21	227		United	States
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after desth with the Maryland to Health and Mental Hygiene. If item 27 is marked other than "naturel", or itame 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	d by Funeral	11. Marital Status t ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 H No		Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify:	
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laryland 212. 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, than	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle, M.		416
arylai should b	10	William N. Smith					a Wilhelm:		
Maryland id 2 should be file th and Mental Hy 27 1e marked oth traumatic event		19a. Informant's Name/Relationship (T)							Zip Code) 21228
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Baltimopermit. Peg Department Important: I any injury conce.		21. Signature of Funeral Service Ligent	2		. Name and Addre		5-2005 Fi brose Fund	inksburg,	The
Dal permi Depa Impo		Chunk	SHOW	13	28 Sulph	ur Spring	g Rd., Art	outus, MD	21227
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ecords, Plaw requires that as been signed b	by	Pan II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of c	
The The ate has page	Completed						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
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Of Phys r this	. To	1 Yes 2 No	1 L Inpatient	2 ER/Outpatien 28b. Time of		4 Nursing H	ome 5 Residen		ocify)
Attending of death.	atior	1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Yea	ir) Injury	28c. Injur Wor M 1	k?` Yes 2 □No	20d. Describe now	injury occurred	
E Diffe	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp	At home, farm, street,	eet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
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To the To the Comp	ž	29b. Signature and title of certifier	2 2	11 -	29c. Licens	e number	290	I. Date signed (Mon	th, Day, Year)
<i>'</i> 2		30. Name and address of person who co	omplets ause f death	(Item 23a) (Type,	Print)	5539	1 Se	ptember	12,2005
<u> </u>		Ming Vi 3320	Benson	Aveni	re. 15	altimo	ive M	anyland	21227
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature K.	boute			/	,

Physic	ian	1. Decedent's Name (First, Mi Nicole	iddle, Last)	Z	-	6	eith			Month	ath per 08	, 2 [°] 005	3. Time of Deal
/Medi Examii		4a. Facility Name (If not institu	ition, give st				4b. City, Town,	or Location of		Сресии		unty of Death	
CAGITIII		Union Memori	ial Ho	spital			Ba.	ltimor	9				
Funeral Director		5. Social Security Number 215-86-189	6. Sex	M 25%F 7. A	ge (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days		4 Hrs. 8 Min.	Date of Bird (Month, Da	th y, Year)	9. Birth	nplace (State or Foruntry)
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E 28 5	rect	10e. Street and Number			10	77.	10f. Zip Code				100 Citizen	of What Cou	
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Depart Import eny inj		21. Signature of Funeral Servi	ice Licensee	and.		22	Name and Address Per 2007	TA	ViS	JV.	FUNG	RAI	HOME TO.M.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar AMEND ITEM #26 per phy 2849 estificates of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day :00 P M ARRICK MONALO 2005 SugT /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 919 DUNDALK Kelmore BALTIMOR If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 20-40-818 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or liems 23a or 28e-f show other treumatic event, the Medical Exampler must be notified at 10d. Inside City Limits MD 1 Yes 2 No Director BUSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? RS 21239 6510 U.S.A by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ₩Idowed 4 Divorced Specify: White Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12+4 DRIVER TROCK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Wilber P LARRICK Bernice MillER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a onald ARRICK JR 6510 Sharen 21239 RD. Balto. Wa 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 6 1 Surial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or 16/65 Luiseburg Cem.

22. Name and Address of Facility Stella Funceal Home
HARTLEY Miller Stella Funceal Home
HARTLEY Miller Stella Funceal Home
RD. Balto Ms 21234 4 ☐ Donation 5 ☐ Other (Specify) White HAll MD 21. Signature of Funeral Service Licensee Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): the attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death Day 5 Other (specify) þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 1 ☐ Yes 2 ☐ No 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Daughter's Hospital: Other: 4 \(\sum \) Nursing Home ို 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 3 Residence 6 XX ther (Specify) Residence Certification:

Division of Vital Records, P.O. Box 68760, After this certificate has been signed funeral director, page 2 should be det To the Hospitel or Attending Physicien: To the Funeral Director: After the completely filled in by the funeral within 24

Baltimore, Maryland 21215-0036

27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year)

29b. Signature and title of certified 29c. License number MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bernett MD ve.

32. Registrar's Sjgnature

State Registrar

Medical

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 **Physician** Month В LeMartine Elaine September 6:05PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Bospital Prince George s Clinton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Funeral 9. Birthplace (State or Foreign 1 M 2 XF 53 Washington. Director 212-66-3155 Yrs July 14.1952 Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event. That Medical Examinar must be ricitified at Completed by Funeral Director Maryland Prince George's Temple Hills 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3701 Brinkley Road U.S.A. 20748 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene. Is marked other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Helen Dorothy Wible Joseph Seneca1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any injury or other traum <u>once.</u> 14708 Main Street Upper Marlboro, Maryland20773 Joseph C. Sauerwein 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 15 1 Durial 2 □ Cremation 3 □ Removal from State
1 □ Donation 5 □ Other (Specify) September Brentwood. Maryland Ft. LIncoln Cemetery 2005 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Suneral 6633 Old Alexandria Ferry Road Clinton, MD20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HICKORIL (wick phologothy /Medical Due to (or as a consequence of): **Examiner** terabs. Curhos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Du to (or as a consequence of) Examiner use as the burial-transit certificate be executed Ri-L that initiated events resulting in death) Last 5 drys Due to (or as a consequence of): the attending physician P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 donknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 2 No 1 Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death Check on one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient P 1 Tyes 2 PNo 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a e Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9/11/01 10024994 1328 Souther Av Charle DC 31. Date filed (Month, Day, Year) gistrar's Signature State 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygiege 0 05 For State Registrer Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 02 PM **Physician** stenber 2005 /Medical 4c. County of Death 4b. City, Jown, or Location of Death Name (If not institution, give street and number) Examiner If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) f Unde 1 Year 8. Date of Birth (Month, Day, Year) 6. Sex Days **Funeral** Hours Months 1 🔀 M 2 🗆 F March 16. New York 1928 Director 130-28-<u>2610</u> Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County 10a, State 28a-f show 1 ☐ Yes 2 No the Medical Examiner must be nutified at Funeral Director Princeton N.J. 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number ō 08540 USA 35 Stonewall Circle or items 23e 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates: 14 Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married White 1 ☐ Yes 2 💢 No Specify Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced naturel Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) ith and Mental Hygiene. 27 is marked other than "r r traumatic svent, the Wed College (1-4or 5+) Elementary/Secondary (0-12) Medicine 5+ Physician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should ba file ment of Health and Mental Hy tent: If item 27 is marked oth 1 00 Ngon Wallev Ling 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health an Importent: If item 27 is: any injury or other trau once. 35 Stonewall Circle, Princeton, N.J. Helen Ling/spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 09/16/2005 Towson, Maryland Hillton Svc. Corp. 5 Other (Specify) * 4 Donation 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Funeral Service Licenses 21. Signature 1050 York Road, towson, Maryland 21204 23a. Par Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 9 days Pnysician Henorhagne disease or condition resulting in death) /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine be executad burial-transit souton Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 ☐ Unknown the detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has 1 🗆 Yes 2 No 1 Yes 2 No certificate 26. Place of Death Check onl one or Attending Physician: 25. Was case referred to medical examiner? Be Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 28d. Describe how injury occurred Diractor: After the 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at 27. Manner of Death 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after within 24 hours a To the Funeral (ro the Hospitei Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Griffying Physicien: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bellimore, MO 21287 32. Resistrar's Signature State THE WEST Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 20 05 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 840/A M Dert /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chapel Hill Nursing RANdallstou Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) OH-24-1923 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 218-14-930 Director NC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other then "naturel", or items 23a or 28e-f show traumatic event, the Medical Examinat must be notified at 10d. Inside City Limits NIA 1 KYes 2 No Funeral Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 MILLINGTON AVENUE 21223 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 207 No Specify: BLACK Specify: è 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If lean 27 is marked other then "ne any injury or other traumatic event." (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 TH GRADE STEEL WORKER STEED NA BETHLEHEM 17. Father's Name (First, Middle, Last) Be (18. Mother's Name (First, Middle, Maiden Surname) THOMPSON MCCOY JESSIE HARRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LN. # 9 RICH (DAUGHTER) CHURCH RANDALLSTOWN LINDA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 09.19.05 OWINGS MILLS MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE an 5151 BALTO. NATU PIKE, BALTO. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congertive Heart failure **Physician** /Medical Examiner schemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). led by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Dinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was a autopsy performed ves 24 No has 1 ☐ Yes 2 █ No 1 Yes To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, it Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification; 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 051051 cause of death (Item 23a) (Type, Print) Rd Ellicolt City, MD

State Registrar 31. Date filed (Month, Day, Year)

6 2005

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32 Registrar's Signature

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 30145 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 0837 BM ri 219 September 11 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hopkins nesohn Hospital timore If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birt **Funeral** Days Hours Min 219-58-7448 Usual Residence of Decedent 1 M 252F Director with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Examinar must be retified at 1 XYes 2 ☐ No Maryland Director nore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 162 or Items 23£ Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Iter 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unemployed IV L 17. Father's Name (First, Middle, Last) Be 2 19a. Informant's Name/Relationship (Type, Print) (Cousin) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If item 27 is any injury or other trau once. 2250 110 Ma 2/2 20c. Location - City or Town, State 20b. Place of Disposition (Name of Bowman -inden 20a. Method of Disposition crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/26/05 * 4 ☐ Donation 5 ☐ Other (Specify) me 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ph L. Russ Funeral Home, P.A. W. North Ave. Batto, Md. 21216 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failifre. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart fail Hemorrhage **Physician** ere bral disease or condition resulting in death) トロ /Medical Due to (or as a consequence of): Examiner En d O Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death Month Day Year 5 ☐ Other (specify) detached the 9 Unknown 9 Unknown Š been signed be should be deta Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy Syndrone 25. Was cast referred to medical performed' certificate 1 Yes 1 Yes 2 No To the Hospital or Attending Physician: After this certific funeral director, Be 26. Place of Death Check on one examiner? Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending hours after death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a pelli Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Flaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 00051

Registrar

State

30. Name and address of

31. Date filed (Month, Day,

0 J

600 North Wolfe Street Bultimore

(ed cause of death (Item 23a) (Type, Print)

trar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 0 5 30146 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month 2005 Physician 12 Sept. 0040 Doris Joanne Murphy /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford <u>Harford Memorial Hospital</u> Havre de Grace Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 03/30/1919 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🕱 F 029-07-6400 86 Massachusetts Director Usual Residence of Decedent 10c. City Town or Location 10d. Inside City Limits 10a State 10h Counts 28a-f show traumatic event, If a Medical Examiner must be notified at 1 XYes 2 ☐ No Director Havre de Grace MD Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Items 23a 21078 100 Revolution St. Apt. 311 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates] 943-45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 Is marked of Helen Murphy William J. Flatley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trai once. 12366 Greenspring Ave., Owings Mills, MD 21117 Mark Murphy- Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/16/05 Aberdeen, MD Harkord Mem. Grdns. 21. Signature of Funeral Service Licensee Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078 232 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, þ 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy Murphy, Dori: Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 | Natural 2 | Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29d. Date signed (Month, Day, Year)

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Registrar

30. Name and address of person who completed caus

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31. Date filed (Month, Day, Year)

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ORIGINAL

32. Regist ar's Signature

29c. License number

12/2005

		1	For State Registrar	state of Maryland /	Departmo Certific				giene Reg. No.	005	30147
**************************************	Physicia	an	1. Decedent's Name (First, Middle, Last) CHARLOTTE		MOO	RE		2. Date of De Month	Day	2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give stre			ity, Town, or L	ocation of Death		4c. (County of Deal	th
	- Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) If Ur Yrs. Mont		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th Year	9. Bird	thplace (State or Foreign
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' O	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Itam 27 is marked other than "natural", or Itams 23a or 28a-f show important: if Itam 27 is marked other than "natural", or Itams at most lear collised at any Injury or other traumatic event, The Medical Examinar most be notified at angle.	Funeral	10000	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No	If Yes,	ecedent of His specify Cuban	panic Origin? (Sp. Mexican, Puerto	ecify Yes or No Rican, etc.)		4. Race - Ame Black, Whit	erican Indian,
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	1 and 2 sho Health and Iam 27 is my			STRONG	1033 W	D. CRE	od Number or Rui	٠ - ١	40	MD.	217.30
Baltimore,	Pages 1 Iment of H lant: If Ita lury or ott		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify)	come	of Disposition (etery, crematory	or other place,		2005	BA	ation · City or	D.
Bal	permit. Page Department of Important: If any Injury of		21. Sgnature of coneral Service Licensee	Street f.	SKA	and Address	=H.	829 H	UPSC M	0 217	224
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	/Medical Examiner	_	resulting in death) Sequentially list conditions.	Due to (or as a consequent Hypertens) Due to (or as a consequent	01	0					years
W	and I-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events could in death) Last	Due to (or as a consequent							
8760	cate be executed physician and the burial-transit	dlcal	L d								
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Ζij	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🖔 No Hos	pital: 1█Inpatient 2□ER	Outpatient 3F	DOA Other	26. Place of Dea	th <i>(Check only</i> ome 5 ☐ Res		Other (Spe	vr.fr.)
on of	After une		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		b. Time of Injury	28c. Injury Work		28d. Describe			City
Division	al or Attendi s after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, fa	ctory, office	•	28f. Location (City or To	(Street and own, State)	d Number or R	ural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Directorpletely filled in by	edical	29a. Certifier 1 Certifying Physic (Check only one)	ian: To the best of my knowle r: On the basis of examination and manner stated.	dge, death occur and/or investiga	rred at the time ition, in my opi	e, date and place nion, death occur	, and due to the rred at the time	cause(s) , date and	and manner as place, and due	s stated. e to the cause(s)
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	\				Sa) (Type, Print) Street	Bolti-	-ore,	MO, 21	201		
	Sta Registi		30. Name and add less of person who com Mark (grant, M.D., 31. Date filed (Month, Day, Year) SEY 1 0 4000	32. Registrar's Signature	porti		,				

State of Maryland / Department of Health and Mental Hygien 005 1 - For State Registrar 30148 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 2005 **Physician** Jean D. Myers Sept 11, 13:45 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 XX Yrs. 579 38 2536 75 Director Washington DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other then "natural", or Iteme 23a or 28a-f ehow emphylury or other traumatic event, the Madical Evantified at once. 10b. County 10d. Inside City Limits 1 Yes 2 No Director Prince Geroge's Maryland Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9113 Simpson Lane 20735 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Nox If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No XX Widowed 4 Divorced Specify Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ralph Windsor Della Biggs ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Myers (SON) 9106 Simpson Lane, Clinton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)

Sept 15ate 2005 20c. Location - City or Town, State 20a. Method of Disposition 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc . 6633 01d Alexandira Ferry Rd, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in titlated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliven 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 KNo Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 2 No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: / I in by the f 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral [29a, Certifier 📜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) (ISO TSKY LUCO). 12070 QCD LINE CENTEL WHODENE, LAD. 25602 PICCISOTSKY MIO. 31. Date filed (Month, Day, Year) State Stew & Spirite Registrar

State of Maryland / Department of Health and Mental Hygien 2005 30149 1 - For Stete Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 13, 2005 2:25 **Physician** MAZER AARON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examinér BALTIMORE MILFORD MANOR NURSING HOME BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAR. 27, 1910 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Months Days Hours Min 95 Director 220-07-5613 MD Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State or items 23a or 28a-f show ther past be notified at 1 ☐ Yes 2 No Completed by Funeral Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4201 OLD MILFORD MILL ROAD 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or iten any injury or other traumatic svent, The Medical Eras, in all once. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ADVERTISING SALESMAN GENERAL ADVERTISING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MAX MAZER LENA COHEN ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 GLENN ELLEN CIRCLE - BALTIMORE, MD 21208 ZELDA WEINER / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CHIZUK AMUNO ARLINGTON 9/15/2005 4 Donation BALTIMORE, MD √ Other (Specify) 21. Signature of Juneral Service Licen se 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Alzheimers Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and is the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 ☐ Yes 2 110 Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ♠No P 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manne Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation after death. 2 🗌 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 | Homicide 24 hours a 29a. Certifier 1 Leartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) aren 170058676 Scittember 14, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 main street suite 200 Reisters town MD 21136 L. Babitt MID 31. Date filed (Month, Day, Year) 32. Paistrar's Signature State Registrar SEP 1 6 2005

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DHMH 17 Rev 1/2001

ORIGINAL

Amend item#31, perDVR, C847, 9/16/05 TT State of Maryland / Department of Health and Mental Hygier 15 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Day Year September Noe1 5:00 A M Roosevelt 2 emi -11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE ST. AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F 75 Director 220-22-8285 13 08 30 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23s or 28s-f show the Medical Examinar must be notified at MYes 2 No Director MD NA Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funerai 21216 U.S.A. 4122 Fairview Ave 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: 3√ Widowed 4 □ Divorced Black "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Monarch Food I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 5th grade Service treumatic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If them 27 is marked oth any injury or other treumatic event 9008. 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Noel Rosie Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Noel-Daughter
20a. Method of Disposition 4122 Fairview Ave, Baltimore, Md, 21216
ce of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md Metro Crematory 9/16/05 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death Cerebro vascular Accident. Immediate Cause (Final disease or condition resulting in death) Physician DAYS /Medical Due to (or as a consequence of): Examiner EARS it ypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Alberoselerosis, YEARS Due to (or as a consequence of): Box 68760, Diabetes YEARS. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery within 24 hours after death. To the Funerel Director: After this certificete has been signed by the atten completely filled in by the funeral director, page 2 should be detached for u. 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) STED MASCOD (1) 16766 SEPTEMBER 11, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATOMS AVENUE, BALTIMORE, YED MASOOD.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

Seriemser 11, 2005

REESEVELT

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygier 0 5 30152 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 6:00 PM M September 3, 2005 <u>Lillian Nichols</u> /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 205 Hawthorne Road Linthicum If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 ☐ F Director 215-64-2553 93 Jan 24, 1912 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan neat of Health and Mental Hygiene.
snt: if item 27 is marked other than "natural; or items 23a or 28a-f show ury or other traumatic event, it a Medical Examinat can be notified at 1 ☐ Yes 2 ☑ No Director Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 Hawthorne Road 21090 Be Completed by Funeral IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 ₹ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emil Griffner Minnie Schmidt ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Namuth/daughter 1121 Armistead Street Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. * 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Ser 22. Name and Address of Facility trector Wade Renald S State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 mon 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shocker heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

a. Schalmac Cali tis Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Monto /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Day Month Year 5 Other (specify) 4☐Pregnant at time of death ate has been signed by the a page 2 should be detached f Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2₽Ño 1 ☐ Yes 2 ☐ No 1 Tyes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To this After this funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14136 9/11/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PALJIT S. SAWHNET Suite 610 Crain Towers Glen Burnie 1061 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

6 2005

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	Physicia	an	1. Decedent's Name (First, Middle, Last)	200			Date of Death Month D	^{ay} 12, 2005 1000 A ^M
	/Medic Examin	al	1DA M. OXFO		4b. City, Town, o	r Location of Death	EPTEMBER 4	12, 2005 1000 A M
			MERCY HOSPITAL		BALTIMOR			NA
	Funeral Director	3	5. Social Security Number 6. Sex 14 - 24 - 5802	M 2BF 7. Age (In yrs. last birthday)	If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Year 19-21-192	9. Birthplace (State or Foreign Country) MD
9	land DW		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	a-f eh	ctor	MD NA	BALTIMOR	E			1 ⊠ Yes 2 □ No
	with the	Director	10e. Street and Number	•	10f. Zip Code		10g. C	Citizen of What Country?
	ne 23	Funeral	4915 POE AVENUE		Was Decedent of H	lispanic Origin? (Specif an, Mexican, Puerto Ric	y Yes or No-	USA 14. Race - American Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show eny injury or other traumatic event, It a Medical Examinar must be notified at once.	ρ	1 Never Married 2 Married 3 Widowed 4 M Divorced	1 Tyes 2 STNo	1 ☐ Yes 2 ☑ No	Specify:		Black, White, etc. Specify: BLACK
15-0	n 72 h "natu e Jica	lete	15. Decedent's Educ (Specify only highest grade	completed) (Give	dent's Usual Docup kind of work done DO NOT use retired	ation during most of working d)	16b.	Kind of Business/Industry
212	d within giene. or then "	Completed	Elementary/Secondary (0-12)	College,(1-4or 5+)	ASHIER			1SF + G
	be filed ital Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)	•		18. Mother's Name (F		en Sumame)
Maryland	should be and Mental is marked o	ပ္	RALPH SMITH 19a. Informant's Name/Relationship (Type	pe, Print) 19b. Maili	ng Address (Street			or Town, State, Zip Code)
	alth ar alth ar 27 is		CONSTANCE CHEW	1	SARATOGA		LTIMORE	, MD 21229
Baltimore,	Pages 1 annent of He ant: If Item ary or othe	100	20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Ri 4 □ Donation 5 □ Other (Specify)	emoval from State 20b. Place of Dispresentary, cre ARBUTUS	matory`or other plac	Date (DQ - 20 -	1	Location - City or Town, State
Balt	permit. Page Department of Important: If eny Injury of once.		21. Signature of Funeral Service License			ss of Facility		
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the death. Do not en		NATUPIKE		Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Finat disease or condition resulting in death)	Hypertensive Ather Due to (or as a consequence of):	rosclerot	ic Cardiova	scular D	isease
68760,	icate be executed physicien and s the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):				
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ds, P.O.	uires that the de n signed by the a Id be detached f	á	Part II. Other significant conditions con	tributing to death but not resulting in the t	underlying cause giv	ven in Part t.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Records,	The law requirate has been si page 2 should I	Completed					24a. Was an autopsy performed?	
/ital	ysicien:] is certifica director, p	Be	25. Was case referred to medical examiner?	Leanital.	104	26. Place of Death (
of	Phys this ral dii	5.7	1 X Yes 2 No Control	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 28a. Date of tnjury 28b. Time of		4 Nursing Home	5 Residence	6 ☐Other (Specify) jury occurred
ion	uttending I death. ctor: After y the funer	atior	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day Year) tnjury		rk? Yes 2 □No		
Division of Vital	al or Atter after de Directo d in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of tnjury - At home, farm, st building, etc. (Specify)	treet, factory, office	28	f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medicai C		sician: To the best of my knowledge, dea ner: On the basis of examination and/or in and manner stated.				
	To the vithin To the comp	Me	29b. Signature and title of certifier	- 1	29c. Licens			Date signed (Month, Day, Year)
			Calexella	8Ah-	OCM	E	SEP	TEMBER 13, 2005
1	T		30. Name and address of person who co	ompleted cause of death (Item 23a) (Type 111 P	, Print) ENN STREE	T, BALTIMOF	RE, MARYL	AND, 21201

State Registrar

31. Date filed (MoSEP 1 = 8 2005

DHMH 17 Rev 1/2001

32 Segistrar's Signature

	For	State of Maryland / Department of Health and	Mental Hygien \(\Omega \cap \Omega \Omega \Cap \Omega \S	3015
-	For State Registrar	Certificate of Death	Reg. No.	3010
1 [Decedent's Name /First Middle 1 as		2 Date of Death	2 Time of D

Physicia /Medica Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menta! Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any futury or other traumatic event, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

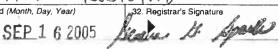
Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deeth.

To the Funaral Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	1. Decedent's Name	e (First, Middle, Last	")							2. Date of Dea Month	ith Da	y Year	3. Time of Death
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er		not institution, give	_	-)	ĺ		_	Location of	Death			County of Deatl	
		Regional			14:11 1 1	Laur		lf Lladay O	4 Hzo			rince Ge	
	5. Social Security N 182-38-47	4.5	X ZM 2□F 7. A	ge (In yrs. Ia 54	Yrs.		Days	Hours 24	Min.	8. Date of Birth (Month, Day	Year)	9. Birtl	hplace (State or Foreign untry)
	Usual Residence of		•	34						03/05/	1951	renn	sýlvania
	10a. State	10b. County		10c. City,	Town or Loc	ation							10d. Inside City Limits
ģ	PA	Bucks		Perk	rasie								1 ☐ Yes 2 🕱 No
Funeral Director	10e. Street and Nur	nber				10f. Zip (Code				10g. Cit	izen of What Co	untry?
<u> </u>	4 High Po	int Road				18	944				USA	.	
nue	11. Marital Status		Was Deceden Armed Forces	?		Vas Decede Yes, specif	ent of Hi fy Cuba	spanic Origi n, Mexican,	n? (Spe Puerto	cify Yes or No- Rican, etc.)		14. Race - Amer Black, White	
by F	1 ☐ Never Marri 3 ☐ Widowed	ed 2X Married	1 ☐ Yes 2 💢 If Yes, Give Year or Dates:		1	☐ Yes 2	No No	Specify:				Specify: Whi	to.
edr	5 E 111d0113d	15. Decedent's Edi			16a. Deced	ent's Usual	Occupa	ation			16b K	ind of Business/l	
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Completed	Elementary/Seco	idary (0-12)	4 years	5+)	CEO					ł	Elec	trical	Lighting
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2	John H. (ckershau	sen					Eva J	ane	Porter			
		me/Relationship (T)										r Town, State, Z	Tip Code)
	Maureen 1 20a. Method of Disp	Kelly Ock	ershausen		4 Hu			kd., P		-			-
	1 □ Buriai 2)	Cremation 3 □I		cer	metery, crem	atory or oth	ner place					ocation - City or 1	
		5 Other (Specify, neral Service Licens		R.A.				-		-		Cheste	
.,	A Maria	O LOCATION	Sim	ith	Mi	tchel	e-Sn	ith F	une	ral Home	2, F	A. ace, MD	01076
	23a Part 1. Enter th	ne disease, or comp	lications that cause	d the death.	Do not ente	or the mode	of dying	g, such as ca	rt, T ardiac o	r respiratory arr	est,	ace, mo	Approximate
	Immediate Cause (t failure. List only o Final			_ ^	1000 A 1	0 10	5111	A	9210	- A - P	5	Interval Between Onset and Death
	disease or condition resulting in death)		a. MYPERT			MANI	OVA	SWU	BR	1)(3	2 19 3	0	
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Examiner	Cause (Disease or that initiated events resulting in death) L		C. Dura to /or o										
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an/Medical	IF FEMALE: 23b. Was decedent		23c. If yes, outcome	e of pregnan	cy							23d. Date of deliv	400
ਹ	in the past 12	months?	1 ☐ Live birth 4 ☐ Pregnant a	2 🗌 Fetal o	death 3 □	Ectopic pre					1	Month	Day Year
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Completed by										24a. Was a		24b. Were aut	topsy findings available ompletion of cause of
E										perform	ned?	death?	2 No
Be (25. Was case referr	-				100.0		26. Place o	f Death	Check only on		1	
၀	1XCXYes 2□	NO	Hospital: 1 ☐ Inpat		R/Outpatient			4 🗀 Nurs				5 □Other (Spec	ufy)
<u></u>	27. Manner of Death 1 Natural	5 Pending	28a. Date of Inj (Month, D.	ury 2 ay Year)	28b. Time of Injury		c. Injury Work			28d. Describe ho	ow injur	y occurred	
Cat	2 Accident 3 Suicide	investigation 6 Could not be	28e. Place of Ir	inor . At hom	an farm etra	M dados		′es 2 □ No		ORf Location (S)	root an	d Number or Pu	ral Route Number.
erti	4 Homicide	determined	building, e	tc. (Specify)	io, iaiii, siie	et, lactory,	OHICE		'	City or Town			rai Hobie Number,
edical Certification;	29a. Certifier (Check only	1☐ Certifying Phy 2 ★ Medical Exami	ner: On the basis	of examination	ledge, death on and/or inve	occurred at	t the tim	e, date and inion, death	place, a occurre	and due to the ca	ause(s) ate and	and manner as place, and due	stated. to the cause(s)
Med	one) 29b. Signature and		and manner s	tated.				number				e signed (Month	
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	A	ess of person who o		-	23a) (Type, P	rint)	ma = 1	. n ₋ 1	44	. M	ar - T -		1
-14	ANA RUGIO, MD 111 Penn Street, Baltimore, Maryland 21201									ore, mai	⊥у⊥а	ша 2120.	

State Registrar 31. Date filed (Month, Day, Year)



			For State Registrar	State of Ma	aryland	l / Depa <i>Cer</i>	artment of H	lealth a	and Me		iene eg. No.	005	3015	55
	Physicia		1. Decedent's Name (First, Middle, La	s"Edna	wd	0	Konsk	1	2.	Date of Deal Month	Day	Year 2005	3. Time of 0	
	/Medic Examin		4a. Facility Name (If not institution, give 5+- [-]12abeth	Nursing	Cen	ter	4b. City, Town, or	1 tim	ore			County of Dea		
	Funeral Director		210 05 0202	V	e (In yrs. la: 97	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	Date of Birth (Month, Day, 0-7-08	Year)	9. Bir Co Ma 1	thplace (Stete or punity) Cy Land	Foreign
	tryland show	_	Usual Residence of Decedent 10a. State 10b. County MD Baltimo:		10c. City,	Town or Lo	cation						10d. Inside City	
	h the Ma or 28a-f	Irect	10e. Street and Number		Albu		10f. Zip Code			1	0g. Citiz	en of What Co		
	ath wit	ralD	5538 Willys Ave				21227				U.S.			
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be notified an once.		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☒ No			y Yes or No- an, etc.)		4. Race - Ame Black, Whil Specify: Wh	te, etc.	
21215-0036	vithin 72 ho ne. han "naturi Neoleal I	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	5+)	(Give life. I	dent's Usual Occup kind of work done	during mos				d of Business	•	
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lan	ould be i Mental I warked of	To Be	Anthony Okonski					Leon	na Fro	nckowi	ak			
Maryland	d 2 should ith and Men it Is marke traumatic		19a. Informant's Name/Relationship Edward B. Okonski		n		ng Address (Street Dutton A						Zip Code)	
ore,	ges 1 and 2 t of Health if Item 27 or other tra		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □	Removal from State	Cer	metery, cren	sition (Name of natory or other place		Date 09-14-	-		ation - City or		
Baltimore,	permit. Pages Department of Important: If II any injury or once.		*4 □ Bonation 5 □ Other (Speci 21. Signature of Funeral Service Lice		Bay		Name and Address From S28 Sulp					timore,		
	g		Daniel (/ Sauce	yell the death							is MD 2	Approximate	
	Physician /Medical		23a. Part 1 Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Cereb	ral	vas	cular	ac	ci'd+	ent			Interval Betw Onset and De	eath
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W	acuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as										
8760,	ate be execul hysician and the burial-trar	cal	resulting in deathy cast	Due to (or as	a conseque	ence or):								
P.O. Box 68	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3]Ectopic pregnancy] Other (specify)	′			23	3d. Date of de Month	,	ear
	w requires that been signed b should be deta	by Pt	Part II. Other significant conditions	contributing to death b	ut not resul	ting in the u	nderlying cause giv	en in Part I.	l.				the cause of de	
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of	g Phys er this seral di	n; To	27. Manner of Death	28a. Date of Inju	iry :	28b. Time of		y at		d. Describe ho			cny)	
Division of	or Attending Fer death. irector: After n by the funer	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not 1 4 Homicide determined	28e. Place of Inj		ne, farm, str		Yes 2		Location (St City or Town	reet and n, State)	Number or R	ural Route Numb	98 <i>r</i> ,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Ce	29a. Certifier 1 Certifying P	hysician: To the best miner: On the basis o and manner st	f examination	viedge, deati on and/or in	n occurred at the tirvestigation, in my o	ne, date an pinion, dea	nd place, and ath occurred	d due to the ca at the time, d	ause(s) a ate and p	and manner as place, and due	s stated. e to the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier	John	m	10	29c. Licens	e number	391	5-	ept	signed (Mont	th, Dey, Year)	005
	Oj		30. Name and address of person who	completed cause of a	death (Item	23a) (Type,	Print) Ue, Bo	Itiv	nure	Ma	ryl	and	2122	7
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signati	ıre	honels?							

State

Registrar

31. Date filed (Month, Day, Year) SEP 1

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2005

32. Redistrar's Signature

Tolers.

State of Maryland / Department of Health and Mental Hygien 2005 30157 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 1600 **Physician** Pol Kowski Septemb er13 ,2005 Dimon /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City. Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 XM 2 ☐ F Yrs. 218-18-5505 81 June1,1924 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location worle ! : If item 27 is marked other then "naturel", or Items 23a or 28a-f show or other traumatic event, the Modical Examinar must be incitified at 1 ☐ Yes 2X No Baltimore Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 7252 Gough Street 21224 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Ie marked other then "naturel; or Ita tX Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 Yes 2XNo Specify.White Completed by 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Beth Steel Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert P.Polkowski /son 7252 Gough Street Baltimore MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State SacredHeartofMAry 9/16/05 permit. Page Department of Important: If ony injury or once. Baltimore * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or complications that caused the death! Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Phermonia **Physician** /Medical Due to (or as a consequence of) Examiner espirator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, physician use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day ò 4□Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown þ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown been sig Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 1 Yes certificate 2 No To the Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 PInpatient 2 ER/Outpatient 3□ DOA Certification: To this After thi funeral 28a. Dite of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of De th 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. I Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funerel Direct completely filled in by 4 - Homicide t Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 13, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HF2664200- K392 John Hopkins Bayview Hospital Eastern Ave. Balto.MD 31. Date filed (Month, Day, Year) 32. Assistrar's Signature State Sporte 16 2005 Registrar

CHARLES PAUL 05-06303 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#17, perFH C847, 9/30/05 TT

1- State of Maryland / Department of Health and Mental Hygiers 10 5

Registrar R 30158 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 1es SEPTEMBER 14,2005 /Medical 4:29P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1401 N.LAKEWOOD AVE BALTIMORE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday).
Yrs. 6. Sex Birthplace (State or Foreign **Funeral** 15 M 2□ F 219-38-4981 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

Int: If item 27 ie marked other than "natural", or iteme 23a or 28a-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 ie marked other than "natural", or iteme 23a or 28a-f ehow treumatic event, the Medical Examinar must be motified at 1 Yes 2 No Directo Vary land more 10e. Street and Number 10f. Zip Code Apt. 304 10g. Citizen of What Country? 1000 TVe. 21 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (YNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race -American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2/2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ongshor aaina eman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlie Paul 2 10 19a. Informant's Name/Relationship (Type, Print) [w 1] e 19b. Mailing Address (Street and Number or Rural Route Number, City or T. wn, State, Zip Code) Mrs. Marie 20b. Place of Disposition (Name of cemetery, crematory or other place) 212 20a. Method of Disposition Date 20c. Location - City or Town, State 9/21/2005 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If eny Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Dulanev Valler 23a. Part | Enter the disease, or complications that chur ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediat Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cause Funeral Home P.A. Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Hospital or Attending Physicien: The law requires that the death certificate be executed ng physician and as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 □Ectopic pregnancy 4 Pregnant at time of death Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 2 No : After this certific tuneral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 🗌 Inpatient Other: 4 Nursing Home 5 Residence 6 MOther (Specify) ٩ 1∑Yes 2 No 2 ER/Outpatient 3 DOA SCHIL 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation М the t 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0 O.C.M.E. SEPTEMBER 15,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET BALTIMORE, MARYLAND 21201 31. Date filed (Month, Day, Year) 32. Registar's Signature State SEP 1 2005 6 Registrar

			1 - For State of Maryland / De Registrar	partment of Health and M ertificate of Death	lental Hygier	
	Physici /Medic		Decedent's Name (First, Middle, Last) Charles Ronald Pyles		2. Date of Death September	P ^{ay} 12, 2005 3. Time of Death 1755 м
	Examin		4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital	4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery
	Funeral Director		5. Social Security Number 577-44-5364 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Months Dave Hours Min	8. Date of Birth April Day Ye	9. Birthplace (State or Foreign Mary Land
	faryland show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Maryland Frederick Frederic			10d. Inside City Limits 1 ☐ Yes ☑ No
	with the N 3e or 28e-	Funeral Director	10e. Street and Number 5902 Meadow Road	10f. Zip Code 21701		Citizen of What Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-1 show mithority or other treumatic event, I're Madical Exertifier must be naitled at once.	by	1 Never Married 2 Married Amed Forces? 1 Never Married 1 Nev	Nas Decedent of Hispanic Origin? (Spinf Yes, specify Cuban, Mexican, Puerto □ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within 72 ho iene. 'then "netur 'te Madical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 ASSI	cedent's Usual Occupation ive kind of work done during most of work by DO NOT use retired) Stant Chief/Securi	ing	Kind of Business/Industry Government
Maryland 2	uld be filed Vental Hygi Irked other Itic event, I	To Be Co	17. Father's Name (First, Middle, Last) Charles A. Pyles	18. Mother's Name	(First, Middle, Maid Margaret (len Sumame)
	and 2 shousalth and N n 27 is mail		19a. Informant's Name/Relationship (Type, Print) Mrs. Teresa A. Pyles, wife 19b. Ma 5902	ailing Address (Street and Number or Rura 2 Meadow Road, Fred	erick, Mar	y or Town, State, Zip Code) cyland 21701
Baltimore,	permit. Pages 1 and 2 Department of Health Importent: If item 27 i any injury or other tre <u>once</u> .		V cemetery c	position (Name of rematory or other place) ivet Cemetery Sept. 17,		Location - City or Town, State rederick, Maryland
Balt	permit. I Departm Importer any inju		21. Signature of Funeral Service Licensee MO0255	²² Keeney and Bastor 106 East Church St	d PA Funer	cal Home ick, MD 21701
	Pnysician /Medical Examiner	er	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cluse on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leadin, to immediate a. Due to (or as a consequence of): Due to (or as a consequence of):	enter the mode of dying, such as cardiac of	or respiratory arrest,	Approximate Interval Between Onset and Death
28760	icate be executed physician and the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	Ventrico la Tas	chycar	ha Iwek
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Vita	sicien: certific irector,	Be	25. Was case referred to medical examiner?	26. Place of Death		
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	Hospitel	edical Co	29a. Certifier (Check only one) Certifying Physician: To the bast of my knowledge, de and manner stated.	path occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
ı	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number	1	Date signed (Month, Day, Year)
•	1		30. Name and address of person who completed cause of death (Item 23a) (Type	07966	9	1/13/05
	15		Keith Lindgran MD 7804	Maph Am Tak	com P	K- MD
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 6 2005	Les .		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepen 05 For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 50 **Physician** 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Randalstown
If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday)
Yrs. 6. Sex **Funeral** Days Min. 0.102M 2□F 560-24-422 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours affer death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or items 23e or 28e-f show the Medical Examiner must be notified at 1 Fes 2 □ No Be Completed by Funeral Director RANDALISTOCOL 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WW. II 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) LECTRICAL ENGINEER permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien. Importent: If tem 27 is marked other the eny injury or other treumstic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 23a. Part1. Enter the disease of complications that caused the wealth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 20 years Arteriosc Physician 100115 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by Carcinoma 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident 5 Pending 1 Tes 2 🗌 No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D0020964 9/12/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 1100 Reisterstown Rd. Suite 202, Pikesville, MD 21208 Jerome H. Ginsberg, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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and 21215-0036 be filed within 72 hours after death with the Maryland ital Hygiene. ad other than "natural", or Items 23a or 28s-1 ahow avent, the Medical Evaninar must be rediffed at	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	13. Was Decedent of Hi If Yes, specify Cubar 1 Yes 2 No	spanic Origin? (Spec n, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Ameri Black, White, Specify:	can Indian, etc.
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Division To the Hospital or Attanwithin 24 hours after death To the Funaral Director: completely filled in by the	edical	one)	sician: To the best of my knowled ner: On the basis of examination and manner stated.	and/or investigation, in my opi	nion, death occurred	d due to the cause(s) at the time, date and	and manner as st place, and due to	ated. the cause(s)
To To con	Σ	29b. Signature and title of certifier	- wi	29c. License	53462_	29d. Dat	te signed (Month, I	Day, Year)
3		30. Name and address of person who co			33-10 2		(17)51	
		31. Date filed (Month, Day, Year)	MD 7845	Dathood	Road	Glen Bur	nie, mp	2106 (
Sta Registi		SEP 1 6 2005	32. Registrar's Signature	Gnortes				

State of Maryland / Department of Health and Mental Hygiene 2005 For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** 2005 12:05 PM^M Lillian Marie Richter 09 14 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Havre de Harford Memorial Hospital Harford 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1 ☐ M 2 🕱 F 02/27/1916 Director Maryland 218-80-2898 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Harford Fallston 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 23a U.S.A. 14. Race - American Indian, Black, White, etc. 2008 Angleside Road 21047 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 XNo
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify. 3 XWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaking Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental I ဂ Louis Amos Mack Mary Marie Boleck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any injury or othar traum once. 9718 Ashlyn Circle - Owings Mills, Maryland Barbara M. Bonicker (niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) Ignatius Ch.Cem. 09/19/2005 Bel Air, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 11750 Belair Road - Kingsville, Maryland 21087 221 adn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ACUTE RENAL FAILURE ~ 5 days /Medical Due to (or as a consequence of): **Examiner** 5 days SEPSIS Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Diffuse colitis Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 9☐ Unknown 5 ☐ Other (specify) 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2□ No 2 1 No 1 🗌 Yes 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No efter death. 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours e To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 09/15/2005 alun D0062522 MD. MPH SURGEON 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYAM JABERINO HARPORD MEMORIAL HOSPITAL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 6 2005 Registrar

Avid Coscia There's Name (First, Middle, avid Coscia Thorman's Name/Relations Thomas of Disposition Burial 2 Cremation Donation 5 Other (Spartice of Funeral Service of Puneral Ser	imore St. 12. Was Dec Armed F. 1 Yes, Gired G. Selection of the State of the S	7. Age (In yrs 58) 10c. C A cedent Ever in torces? 2 DX No ive Dates:) (1-4or 5+) er State 20b.	ity, Town or L rbutus J.S. 13. 16a Dece (Give life) Cash 19b. Maili 540 Place of Dispository, and undon Place 2	Dulaney Dulaney If Under 1 Year Months Days Ocation 10f. Zip Code 21227 Was Decedent of Hill Yes, specify Cube 1 Yes 2 No Dedent's Usual Occup a kind of work done of DO NOT use retired ing Address (Street & Council	If Under 24 Hrs. Hours Min. Itispanic Origin? (San, Mexican, Puert Specify: Pation during most of word word) 18. Mother's Nam Betty and Number or RL. Street	Month Sept. B. Date of Bir (Month, Da June 1 Decify Yes or No of Rican, etc.) Rking me (First, Middle, Fowble	Day Year Year 12, 2005 4c. County of De Balt th year) 9. Even 1947 10g. Citizen of What of U. S. A. 14. Race - Ar Black, WI Specify: 16b. Kind of Business Defens Maiden Sumame)	4:20 P sath cimore Sirthplace (State or Fo. Country) Maryland 10d. Inside City Lit 1
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of Frequency of that intitated events resulting in death) Last IF FEMALE:								
MALE: Vas decedent pregnant in the past 12 months? ☐ Yes 2 ▼ No ☐ Unknown		23d. Date of d Month	elivery Day Year					
Other significant condition	ons contributing to d	leath but not res	sulting in the u	underlying cause give	en in Part I.		_	to the cause of death
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as case referred to medica aminer? Yes 2 X No	Hospital: 1 🗆] ER/Outpatier	nt 3 DOA Othe		th (Check only or	ne)	
Accident investi	not be 28e. Place	e of Injury - At h	Injury	M 1 🗀 🖰	/ at k?	28d. Describe h	now injury occurred	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
Dreck only 2 Medical	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,							nth, Day, Year)
	miner? Yes 2 X No Iner of Death Natural 5 Pendia Accident Suicide 6 Could Homicide 6 Could determ outifier 1 X Certifyin heck only 2 Medical	miner? Yes 2 X No ner of Death Natural 5 Pending Accident Suicide 6 Could not be determined Activitier 1 Certifying Physician: To the beck only 1e) Hospital: 1 28a. Date (Mor and Suicide of Mor and Sui	miner? Yes 2 X No ner of Death Natural Accident Suicide Homicide Accident Suicide Homicide 1 X Certifying Physician: To the best of my knek only 12 Medical Examiner: On the basis of examinating and manner stated.	miner? Yes 2 X No ner of Death Natural Accident Suicide Homicide Accident Suicide Homicide 1 Certifying Physician: To the basis of examination and/or in and manner stated. Hospital: 1 Inpatient 2 ER/Outpatien 2 (Month, Day Year) 28b. Time of (Mon	Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other Natural Suicide Homicide 28a. Date of Injury 28b. Time of Injury 28c. In	Miner? Yes 2 X No Ner of Death Natural Natural Accident Suicide Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated. The spital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Homosoft	autop perfor a case referred to medical miner? Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence of Death (Check only of Nursing Home) Accident investigation investigation and of Could not be determined belief belief on the course of Injury - At home, farm, street, factory, office 286. Place of Death (Check only of Other: 4 Nursing Home 5 Residence of Death (Month, Day Year) 287. Injury at Work? 1 Yes 2 No 288. Date of Injury - At home, farm, street, factory, office 288. Place of Injury - At home, farm, street, factory, office 289. Place of Injury - At home, farm, street, factory, office 286. Location (Society of City of Tow Injury of Injur	autopsy performed?

State of Maryland / Department of Health and Mental Hygier Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 6:26 PM September 11.2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview Medical Center 7. Age (In yrs. last birthday) 8. Date of Birth (Menth, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Hours 7/ **Director** Usuel Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic event, the Madical Examiner must be notified at Funeral Director 1 ☐ Yes 2 No Dunda K ma 10e. Street and Number 10g. Citizen of What Country? C.SA. OUR SEASON VERR. A3 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 SYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Be Completed by Specify: Whil 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. ondary (0-12) College (1-4or 5+) SANITATION Public Works 's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be none of Health and Mental t of Health and Mental Robert Beese 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gote) MO FRIOND 3105 FOUR SEASON 20a. Method of Disposition permit. Pages '
Depertment of F
Important: If Ite
any injury or ott 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW ABVIS JY FUNERAL HOME ASTERN AVE. BALTO Md- 216 21. Signature of Funeral Service License 23a. Part1. Enter the dinaal e, or complications that caused the death. Do not enter shock, or heart fail. ... List only one cau ... on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypoxic

Due to (or as a consequence of): respiratory 6 hours /Medical Examiner days Preumonia Sequentially list conditions, if any, leading to immediate cause [Disease or injury] Examiner Due to (or as a consequence of). use as the burial-transit The law requires that the death certificate be executed Vascular Accident Cerebrol 19 months that initiated events resulting in death) Last been signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 XNo Certification: To 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 2 Accident death. 1 Yes 2 No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral (To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Ph.O., M.D. Grette Brown RE5-000 September 11, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lynette Brown, Johns Hopkins Hospital, Boo North Wolfe, Baltimore, Maryland 21287 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State SEP 1 6 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiehoe00530165 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Paul A. Robinson Sr. 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kosedal 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days Hours 362-62-9959 Director Mississippi Usual Residence of Decedent 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or Iteme 23a or 28e-f ehow any injury or other treumatic event, the Medical Examinat must be notified. 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 127 Akin Circle 21220 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Specify. þ Specify: 3 Widowed 4 Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Forklift Driver Warehouse 17. Father's Name (First, Middle, Last) unknown 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ္ Mattie Lee Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rachel F. Robinson/Wife 127 Akin Circle Middle River, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 09-17-05 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liceosee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor St. Balto, MD 21217 23a Part I Enter the disease or complications that caused the death. Do not enter the mode of duing such as cardiag or recoverted extends **Physician** /Medical **Examiner** Physician/Medical Examiner Be Completed by Medical Certification; To

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Division of Vital Records, P.O. Box 68760, cete has been signed by the page 2 should be detached this certificete After the within 24 hours efter use.... To the Funeral Director: Aft

with the Maryland

Baltimore, Maryland 21215-0036

shock, or heart failure. List only dr	ne cause on each line.	a l	or dying, such as cardie	c or respiratory arrest,	Interval Between
Immediate Cause (Final disease or condition resulting in death)	Metastat	ic Lu	ing Can	cer	Onset and Death
Toodining in dodain)	Due to (or as a consequence	of):			
Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):			
that initiated events resulting in death) Last	Due to (or as a consequence	of):			
	l				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	n 3 □Ectopic preg 5 □ Other (spec	nancy My)		23d. Dale of delivery Month Day Year
Part II. Other significant conditions cor	tributing to death but not resulting	in the underlying cau	se given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Munknown
				24a. Was an autopsy performed?	
25. Was case referred to medical examiner?			26. Place of De	ath Check only one)	
1 ☐ Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/O	utpatient 300A	Other: 4 Nursing I	Home 5 ☐ Residence	6 ☐Other (Specify)
27. Manner of Death 10 Natural 5 Pending 2 Accident investigation		Time of 28c Injury M	Injury al Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fabuilding, etc. (Specify)	arm, street, factory, o	ffice	28f. Location (Street City or Town, Sta	and Number or Rural Route Number. ate)
29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of my knowledg ner: On the basis of examination ar and manner stated.	e, death occurred at nd/or investigation, in	the time, date and place my opinion, death occi	e, and due to the cause urred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and little of certifier	-	29c. L	icense number	29d. D	Date signed (Month, Day, Year)
Y 1034a	nu mo.	D	21466	8 Se	btember 12 2005
of Name an address of person who co	mpleted cause of death (Item 23a) 2 9000 Frankli	(1)	e Drive	Balt, mo	ptember 12, 2005 re 4d. 21237

Registrar

State

State of Maryland / Department of Health and Mental Hyg

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Reg. No.						

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Physician /Medical Examiner Funeral Director	
C	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "or thems 23a or 28e-1 show eny injury or other traumatic event, the Medical Examinar must be notified at once. To Be Completed by Funeral Director	

Phy /M Exa

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Division of Vital Records, P.O. Box 68760,

		Registrar				061	uncate or	Dealli		Reg. No).			
ysicia	in	1. Decedent's Name	First, Middle, La	st)			RABINOVI	Т7	2. Date of Month		y 12 Year	3. Time of Death 7:00 P M		
Medic		4. Facility Name (I		e street and number				or Location of D			. County of Dea		_	
amin	er	, ,				т			eam	40				
-		5. Social Security N		IMORE-GIL		HRIST TOWSON (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.				BALTIMO 8. Date of Birth 9. Birthplace (
eral ⁻ ctor		212-20		M 2 7 F	79	Yrs.	Months Days		SEPT.	Day Year	926	thplace (State or Foreigr ountry) MD	1	
		Usual Residence of			1					Lod Inside Challes				
	_	10a. State	10b. County		10c. City	, Town or Lo						10d. Inside City Limits		
	cto	MD	N/A	\		BALT	IMORE					1 X Yes 2 □ No		
	Sire.	10e. Street and Nur					10f. Zip Code			10g. Ci	tizen of What Co	ountry?		
	a	3331 F/	ALLSTAFF	ROAD #103				21209				USA		
	Funeral Director	11. Marital Status	V	12. Was Decedent Armed Forces	?	S. 13.	Was Decedent of f Yes, specify Cub	Hispanic Origin? oan, Mexican, Pe	? (Specify Yes or uerto Rican, etc.)	No-	ne <i>r</i> ican Indian, nite, etc.			
ery injury or other traditions event, in making the first that the content of the	by F	1 Never Marri	ed 2 X Married 4 □ Divorced	1 ☐ Yes 2 X If Yes, Give Year or Dates:	1 Yes 2X No Specify:						WHITE			
	ted		15. Decedent's E	ducation			dent's Usual Occu			16b. K	(ind of Business	/Industry	-	
	pie		ify only highest gra	ade completed) College (1-4or	(Give kind of work done during most of working life. DO NOT use retired)					ing				
	Completed	Elementary/Seco	12			HOME	MAKER				OWN HOM	IE		
	Be (17. Father's Name	(First, Middle, Last)					Name (First, Mide	dle, Maider	n Sumame)			
	2	JACK				RUDO	LPH	GERT	RUDE			CHASEN	_	
1		19a. Informant's Na			DAND	1	ng Address (Stree							
			O RABINOV	11Z / HUS	BAND		FALLSTA	FF ROAD		_			_	
		20a. Method of Disp		Removal from State	, a	emetery, crei	sition (Name of natory or other pla		Date		ocation - City or			
			5 ☐ Other (Special		BAL							STOWN, MD		
nce.		21. Signatura Fu	neral Service Lice	nsee) 22	2. Name and Addr	ess of Facility	SOL LEVI	NSON	& BROS.	, INC.		
a	-	100	00/	Lun							SVILLE,	MD 21208		
		shock, or hea	rt failure. List only	plications that cause one cause on each	ine.	n. Do not ent	er the mode of dy	ing, such as care	diac or respirator	y arrest,		Approximate Interval Between Onset and Death		
an		Immediate Cause (Final disease or condition resulting in death) a. UNG CANCLV												
al er		roducing in doucin,		Due to (or a	s a consequ	uence of):								
W	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Objects or injury										_		
	n ju	cause. Enter Under Cause (Disease or	rlying injury		,	,								
	Examiner	that initiated events c												
	edic			· · · · · · · · · · · · · · · · · · ·									_	
	an/Medical	IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, outcome	e of pregna	ncy	Ectopic pregnanc				23d. Date of de	livery		
	lcia	in the past 12		4☐Pregnant a	at time of de	eath 5	Other (specify)	.у		_	Month	Day Year		
	Physici	9 🗆 Unknown		9Ll Unknown									_	
	by F	Part II. Other signif	icant conditions	contributing to death	but not resu	ulting in the u	nderlying cause gi	ven in Part I.	23e. D	id tobacco	use contribute to	o the cause of death?		
	ed								- 1	Yes 2	□No 3□Pi	robably 4 Unknown		
	Completed								24a. W	as an	24b. Were at	utopsy findings available completion of cause of	,	
	E O								pe 1 □ Ye	normed?	death?			
	Bec	25. Was case refer	red to medicat					26. Place of	Death (Check on	/			-	
	10	examiner?	No	Hospital: 1 Inpat	ient 2 🗆	ER/Outpatier	t 3 DOA	her: 4 🗆 Nursin	g Home 5 ☐ R	esidence	6 Other (Spe	city) LOSD(CD		
		27. Manner of Deat	h 5 🗆 Pending	28a. Date of Inj (Month, D	ury ay Year)	28b. Time of	28c. Inju	iry at	28d. Descrit	e how inju	ocurred	7,037.3	-	
	atic	2 Accident	investigatio					Yes 2 □No						
	Certification:	3 Suicide 4 Homicide	6 Could not be determined	286. Place of Ir	itc. (Specify		eet, factory, office			n (Street ai Town, Stati		ural Route Number,		
	Ce		-										_	
	edical	29a. Certifier (Check only	Certifying Pl 2 Medical Exa	nysician: To the bes miner: On the basis	of examinat	wledge, death	n occurred at the t vestigation, in my	me, date and plopinion, death o	ace, and due to t	he cause(s ne, date an) and manner as d place, and due	s stated. e to the cause(s)		
	Med	29b. Signature and		and manner s	tated.			se number			ite signed (Mont			
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		30. Name indiaddr	N COM D	completed cause of	death (Item	(Type,	() lano	(O1 ()	- 77h	129 N	MD 7	1204		
Sta	te	31. Date filed (Mon	th, Day, Year) •	32. Regis	trar's Signa	ture	VVV	~~ \ (70.0				_	
gistra	-		SED 1 C			10	N. M.							

State of Maryland / Department of Health and Mental Hygie 15 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** SAISbeR 100 A M 5 Hirley 2005 /Medical DERT 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GRAPE Seed BALTIME BAHIMAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Days Hours Min. Yrs. 212-52-7690 MDDirector Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show item 27 is marked other than "naturel", or Items 23a or 28a-f shov other traumatic event, the Madical Examinar must be notified at PARKUILLE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. A 21234 Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 27 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Inportent: If item 27 is marked other than "naturel", or iter any injury or other traumatic avent 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No à Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) CLERK CONSTRUCTION NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WALTER FISHER MARY 6MP/0N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAISberg BAHO. MD SCOTT 5332 Abbeywood CT. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 9/16/05 1 Burial 2 Cremation 3 Removal from State BAYVIEW CremaTory BA HO * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility STella Fraeral Home CHTD. HARTLEY MINER 21. Signature of Funeral Service Licensee BAIto.Ms 7527 harford for 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death · Arteriosclerotic Immediate Cause (Final **Physician** (andioVascular 10 year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a sonesquanes of): burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the b IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 90 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? Yes 2 No death? 1 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death Check onl one examiner? 1 XYes 2 □ No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1866 September 12, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 Philip Militello T Lutherville, Maryland LV-10mble 32. Registrar's Signature State 1 6 2005 College . Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Robert E. Smith September 13, 2005 /Medical 12:50A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center <u> Annapolis</u> Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1**X**□M 2□ F Months Days Hours Director Yrs. 1-18-1936 69 223-46-5647 Virginia Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County ir than "natural", or items 23a or 28a-f ehow The Madical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2X No Directo Maryland Queen Anne's Stevensville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 403 Kent Way 21666 death 1 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1959–63 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) yrs. Chemical Engineer Department of the Navy other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Arthur D. Smith Virginia Isabel McLemore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nina F. Smith/ Wife 403 Kent Way, Stevensville, MD 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 【**XCremation 3 ☐ Removal from State ** 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 9-15-05 Edgewater, MD 21. Signatur of Juneral Service Dicenses 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician may earls /Medical Die to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or danying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 🗀 Probably 1 ☐ Yes 2 ☐ No Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has 2000 2 No Yes To the Hospital or Attending Physician: within 24 hours after death. funeral director, Be 25. Was case referred to medical 26. Place of Death Check onl one examiner's Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 2 1 ☐ Yes 2 ☐ 1 Vior atient 2 ER/Outpatient 3 DOA 28a. Dale of Injury (Month, Day Year) Certification: 27. Manner of Douth 28b. Time of 28d. Describe how injury occurred 7 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation M 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only € Medical Examiner: Ø onel 29b. Signature and title 29c. License number 29d. Datersigned (Month, Day, Year) 200 30. Name and addre person who completed cause of death (Item 23a) (Type, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Hazel H. Smith September 11,2005 6:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Respite Home on South Haven Annapolis Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | 5-21-1915 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛱 F Director 115-03-6067 90 Yrs New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Evantual traus be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Directo Maryland Anne Arundel Davidsonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 731 Petersburg Rd. 21035 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: White 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker **Home** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Hahn Charlotte Berger ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur H. Smith, Jr./ Son 7327 Prince George Ct., Spring Hill, FL 34606 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Kalas Crematory * 4 □ Donation 5 □ Other (Specify) 9-13-05 Edgewater, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a disease or condition resulting in death) Wear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 W No 23d. Date of delivery 3 Ectopic pregnancy for Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2: autopsy 2 No 2 Yes 4 or Attending Physician: after death. Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) TSSISTED Other: 4 Nursing Home 5 Residence 6 Tother (Specify) 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 50725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vetegans Hwy Millers ville MD 21108 2083 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Mar	yland / Dep <i>Ce</i>	artment of F	lealth and M <i>Death</i>	ental Hygie Reg.	2005	30170
20		\exists	Decedent's Name (First, Middle, Last	it)				2. Date of Death		3. Time of Death
	Physici /Medio		Cecilia E. Sha	ffer				Month September	Day Year	5 18:45 M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	
			ST. AGNES HO				ore			
12	- Funeral Director		5. Social Security Number 6. S. 216-20-9868	ex 7. Age (☐ M 2 ☐ F	In yrs. last birthday, 78 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye 8-4-192	ear) C	rthplace (State or Foreign country)
77			Usual Residence of Decedent					0-4-192	Z / Ma	aryland
•	arylar ehow	_	10a. State 10b. County	1	0c. City, Town or L	ocation				10d. Inside City Limits
	he M	Funeral Director	MD Baltim 10e. Street and Number	ore	Baltimo		ands			1 Yes 2 No
	with the or	ក់		3		10f. Zip Code			. Citizen of What C	ountry?
	ne 23	era	2839 Tennessee	12. Was Decedent Ev	er in U.S. 13.	Was Decedent of H			S.A.	erican Indian.
21215-0036	72 hours after death with the Maryland natural', or Iteme 23a or 28e-f ehow dicel Exaciliner must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:		If Yes, specify Cubin 1 ☐ Yes 2 🖾 No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	Rican, etc.)	Black, Whi	ite, etc.
5-0	"natural",	etec	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occup	ation during most of working	166	b. Kind of Business	s/Industry
121		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of workird)			
	ifiled within Hygiene. other then		17. Father's Name (First, Middle, Last)		Home	emaker	18. Mother's Name		ownhome	
Maryland	d la d	To Be	Hunter Robinso	n			Elizabet			
37	2 should be and Menta le marked aumatic ev	ř	19a. Informant's Name/Relationship (7		19b. Maili	ng Address (Street	and Number or Rura			Zip Code)
	alth a		Earl F. Shaffe	r/Husband			see Ave			
J.	es 1 at of Hea if Item ir othe		20a. Method of Disposition		20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	(a)	ate 200	. Location - City or	r Town, State
Ë	Peges nent of ent: If It ury or o		1 🔀 urial 2 🗆 Cremation 3 🗆 4 🗓 Donation 5 🗆 Other (Specify		Loudon I	Park Cem	nétery 9-	-12-05 B	Baltimor	e, MD
Baltimore,	permit. Peg Department Importent: I any injury o		21. Signature of Funeral Service Lioan	Sun h	1 -	2. Name and Addre	Pallix	rose Fu	neral H	Home, Inc. Md 21227
36			23a. Part1. Enter the disease, or composhock, or heart failure. List only	olications that caused the	e death. Do not en	ter the mode of dyir	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	, Seps						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c						110000
(6)	- Zarillici	<u>.</u>	Sequentially list conditions,	b. Due to for as a r	Caracteristic Ca					
10	ted nslt	nine	any leading to immediate cause. Enter Underlying Cause (Disease or injury	Chief to (Criss a r	unsequence ory					
-	icate be executed physician and s the burial-transIt	Examiner	that initiated events resulting in death) Last	c. Due to (or as a c	onsequence of):					
58760,	se be	dicail		d.						
_		Ψ.	is service							
P.O. Box	The law requires that the death certifi tie has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 (4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
	res that signed b be deta	by Pt	Part II. Other significant conditions of	ontributing to death but i	not resulting in the u	inderlying cause giv	en in Part I.	23e. Did tobacc	co use contribute to	o the cause of death?
rg	w require been sig should b		Renal	Failure				1 🗆 Yes	2 1 0 3 □ P	robably 4 Unknown
Division of Vital Records,	e taw re has be	ompieted						24a. Was an autopsy		utopsy findings available completion of cause of
<u> </u>		Con						performed	l? death? No 1 ☐ Yes	
/ita	ician: certifica rector, p	Be	25. Was case referred to medical examiner?	Heavital.			26. Place of Death	(Check only one)		
_	Phys this al dir	To	1 Yes 2 No	Hospital: 1 Ninpatient 28a. Date of Injury	2 ER/Outpatier		4 U Nursing Hom	e 5 Residence		ecify)
Ö	or Attending Physician: tfer death. Director: After this certifica in by the funeral director, p	Certification:	Natural 5 Pending investigation	(Month, Day Y	ear) Injury	Wor	yat k? Yes 2 □ No	8d. Describe how in	njury occurred	
/isi	Atten deal octor	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	- At home, farm, str			8f. Location (Street	t and Number or R	ural Route Number,
ă	s effe	Sert	4 Homicide determined	building, etc. (Specify)	•		City or Town, St	tate)	
	To the Hospitel or Attent within 24 hours effer deati To the Funerel Director: completely filled in by the	Medical (CHECK ONLY S MEDICAL CXBIL	ysician: To the best of r	amination and/or in	h occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurre	nd due to the cause d at the time, date	e(s) and manner as	s stated.
	o the ithin 2 o the	Med	one) 29b. Signature and title of certifier	and manner stated	3.	29c. License			Date signed (Mont	
	F3F8			2	117					
•	h		Menbere 30. Name and address of person who of	completed cause of deat	h (Item 23a) (Tune	Print)	TOOSAS) Se	rrembe	108,2005
			Menbere Bahru	, 900 Cato	· Ave	Baltime	re. Mn	21229		
	Sta	te	Menbere Bahru 31. Date filed (Month, Day, Year) SEP 1	32. Registrar	Signature	1.0	1112			
	Registr	ar	SEP 1	6 2009	Marie St.	fig David	7			

SHAFFER

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CECILIA

05 - 6141Amend Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiers 0 5 UNKNOWN B.K.S JOHN SHILOW SR - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Day **Physician** John Wilmer Shilow, Sr. SEPT. 2005 0735 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)
1143 NATICOKE STREET 4b. City. Town, or Location of Death Examiner BALTIMORE CITY If Under 1 Year | II Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 9. Birthplace (State or Foreign 12-25-1956 Maryland 5 Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1□M 2□F 219-62-1413 48 Yrs. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 27 is marked other then "natural", or items 23s or 28s-f show traumatic event, its Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director MD Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 20 West George Street 21157 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐ No Specify: If Yes, Give Year or Dates: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene Shilow, Catherine May Tudor ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if item 27 ie m any injury or other traum once. 20 West George Street Westminster MD 21157 John W. Shilow, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal Irom State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 9-12-2005 Baltimore, MD 22. Name and Address of Facility Ambrose Funeral Home, 21. Signature of Funeral Service License 1328 Sulphur Spring Rd. Arbutus Md 21227 23a. Part1. Enter the disease, accomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Narcotic Intoxication disease or condition resulting in death) /Medical Due to (or as a consequence ol): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of) Examiner Physicien: The law requires that the death certificate be executed use as the burial-transit Division of Vital Records, P.O. Box 68760. ettending physicien and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? t ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ cete has been signed, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 □ No 24a. Was an certificete has 1. Yes 2 □ No director, 25. Was case relerred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ YYes 2 No AT SCENE this 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28a. Date of Injury Figure 1. Day Year) 28d. Describe how injury occurred Attending 5 Pending investigation 1 Natural t ☐ Yes 2 No 2 Accident 9/8/2005 7:20 A efter death Director: unk Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1143 Nanticoke 28e. Place of Injury - At home, larm, street, laclory, office building, etc. (Specify) filled in by 4 - Homicide Scene Street Baltimore, MD 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E SEPT. 8, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 PENN STI ANA 111 PENN STREET, BALTIMORE, MARYLAND 21201 MM) 31. Date filed (Month, Day, Year) SEP 2005 Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiepen 05 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Day **Physician** September 15, Karen Elaine Selbv 2005 5:25A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Gilchrist Hospice Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Director 359-38-8833 43 Sept 19, 1961 Illinois Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28e-1 ehow other treumatic event, the Medical Examinat must be notified at 1 Yes 2 No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 7922 Rustling Bark Court 21043 Itете 23а USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ò Specify: White 21215-0036 1 ☐ Yes 2X No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 and 2 should be filed within 1 and 2 should be the within and Mental Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) Title Company Settlement Office Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be Bernard John McGuire Joan Phyllis Gardner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If item 27 is eny injury or other tree Scott A. Selby/Husband 7922 Rustling Bark Court Ellicott City, ND 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition September t ☐ Burial 2 X Cremation 3 ☐ Removal from State Arundel Crematory 16, 2005 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M01251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner burial-transft Due to (or as a consequence of) Box 68760. physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate hes autopsy rmed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; the Hospitel or Attending I hin 24 hours after death. the Funeral Director: After 1 Natural 2 Accident 5 Pending investigation 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) wo of death (Item 23a) (Type, Print) GBMC 32. Registrar's Signature State 2005 Registrar

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 5

			1- State Registrar	Pertificate of Death	en 2005 30173
	Physici	an	Decedent's Name (First, Middle, Last) T T T T T T T T T T T T T	2. Date of Death Month	3. Time of Death
	/Medic	cal	Joann Scott	Aug. 21	, 2005 8:00 A.M
1	Examir	ner	4a. Facility Name (If not institution, give street and number) 8 Acorn Circle Apt. 202	4b. City, Town, or Location of Death Towson	4c. County of Death Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	day) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day,	Year) 9. Birthplace (State or Foreign Country)
	Director		214-78-5414 1□M 2₽F 46 Yr	Months Days Hours Min. (Month, Day, July 9,	1959 Maryland
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of the County 10c. City, Cit	or Location	10d. Inside City Limits
	Mary a-f sh	to	Maryland Baltimore Towso	n	1 □Yes 2 □No
	ith the	Funeral Director	10e. Street and Number	10f. Zip Code	g. Citizen of What Country?
	ath w	rai	8 Acorn Circle Apt. 202	21286	USA
	item item	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	 Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 	 Race - American Indian, Black, White, etc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-1 show ha Madical Examinar must be notified at	by	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: Black
5-0	72 ho	Completed	15. Decedent's Education 16a. D (Specify only highest grade completed) ((ecedent's Usual Occupation 1	6b. Kind of Business/Industry
121	within ane. than "	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired)	
	Hygie Hygie other		Unk. INE	ver Employed 18. Mother's Name (First, Middle, M	aiden Sumame)
an	lid be lental rked o	To Be	Henry Scott, Sr.	Dixie Thomas	-
Maryland	perriat. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Madical Examinator and be notified at an once.		19a. Informant's Name/Relationship (Type, Print) 19b. N	lailing Address (Street and Number or Rural Route Number, and Number of Baltimore	City or Town, State, Zip Code)
	and sealth m 27				
õ	ages 1 of H or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery,	Syark Read Baltimore, 2 crematory or other place) rmel Cemetery 8/26/05 Du	0c. Location - City or Town, State
Baltimore,	it. Pa intmer injury in		4 Donation 5 □ Other (Specify) Mt. Ca: 21. Signature of Funeral Service Loensee	rmel Cemetery — Pu 22. Name and Address of FacilitChatman-Ha	
Ва	permit. Departitimport			5240 Reisterstown Rd Ba	
			23a. Part. Enter the disease, or complications that caused the death. Do not prock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or respiratory arres	Interval Between
4	Pnysician		Immediate Cause (Final disease or condition resulting in death)	s mellitus	Onset and Death
	/Medical Examiner		Due to (or as a consequence of)	. 7.0	3
		er	Sequentially list conditions, if airly, leading to immediate cause. Enter Underlying Cause. [Disease or injury]	ral Visase	cya, s
1	cuted od ransit	Examiner	that initiated events		
.00	oe exe		resulting in death) Last Due to (or as a consequence of)		
68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Medical	d		
Вох	eath certii attending for use a		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	2 D5 4 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	23d. Date of delivery
	e deatl	Physician/	in the past 12 months? 1 Yes 2 No 9 Unknown	3 □ Ectopic pregnancy 5 □ Other (specify)	Month Day Year
P.0	res that the de signed by the a be detached t	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	and the second of Park	
ds,	signe d be d	d by	Human Immuno Deficiency		acco use contribute to the cause of death? 2 No 3 □ Probably 4 □ Unknown
CO	w requir been s should	lete		24a. Was an	24b. Were autopsy findings available
Vital Records,	The lav ate has page 2	Completed		autopsy perform	prior to completion of cause of death?
ita		Be C	25. Was case referred to medical examiner?	1 ☐ Yes 2 ☐ 26. Place of Death (Check only one.	VIII
of V	Physicien: this certific ral director,	To	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa		ce 6 ☐Other (Specify)
	ding h. After fune	tion:	27. Manner of Death 1 Matural 5 Pending (Month, Day Year) 2 Accident investigation		injury occurred
Division	or Attending after death. Director: After in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm	street, factory, office 28f. Location (Stre	et and Number or Rural Route Number,
-	7 6 F C	Certification	4 ☐ Homicide determined building, etc. (Specify)	City or Town,	State)
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical	Check only 2 Medical Examiner: On the basis of examination and/o	eath occurred at the time, date and place, and due to the cau r investigation, in my opinion, death occurred at the time, dat	se(s) and manner as stated. e and place, and due to the cause(s)
	vithin ;	Med	one) and manner stated. 29b. Signature/and title of tertifier		f. Date signed (Month, Pay, Year)
			Kurch & mo	D00615410	08/24/2005
(30. Name and address of person with completed cause of death (Item 23a) (Ty	•	
	1/		31. Date filed (Month, Day, Year) 22. Registrar's Signature	St. Baltimore, MD 2120	(
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	sale)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiege 0 5 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Larn Jackson Strother Sept 7, 2005 6:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montomery Naval Medical Center National If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1, M 2 □ F Months Director 235 48 4394 72 Feb 18, 1933 West Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show other traumatic avant, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7017 Groveton Drive 20735 U.S.A. or Itams 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 2 should be fillad within 72 hours after on and Mental Hygiena. 1 Never Married 2 Married NGYes 2□No 1952 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by White 3 Widowed 4 Divorced 1956 Year or Dates: 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Supervisor 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Military Aircraft Mechanic 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Larn L. Strother Georgie A. Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is m any injury or other traum <u>once</u>. Patricia J. Strother (Wife) 7017 Groveton Drive, Clinton, MD 20735 20a. Method of Disposition

ALA Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept 13, 2005 20c. Location - City or Town, State Pages 1 Maryland Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Samio Alexandira Ferry Rd, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Non- Small Cell Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the first linderlyin. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes XXNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1□ Yes Xx No Fo the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 💢 💥 o 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 X Xnpatient this 27. Manner of Death 1 X Matural Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred : After I 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide within 24 hours a To the Funaral C 1 XXertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature

6t g

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) 32. SEP 1 6 2005

Thanh D. Hoang

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MC USA



0102201771 (Va)

NATIONAL NAVAL MEDICAL CENTER

09/13/2005

Physic /Medi		1. Decedent's Name (First, Midd						Sin		2. Date of De Month Septem	ber 1	1 2	Year 005	3. Time of 0643	Death
Examin	ner	4a. Facility Name (If not institution The Johns Hopkin 5. Social Security Number	6. Sex	um <i>ber)</i> 7. Age (In yrs. Ia	ast birthday)	4b. City, To Baltin If Under 1	Year	City If Under:	1 24 Hrs.	8. Date of Bi	irth		n/a	place (State o	r Fore
Director		218-41-1410 Usual Residence of Decedent 10a. State 10b. Count	1 X M 2 □ F	69	Yrs.		Days	Hours	Min.	(Month, Da		936_	Guy	ntry) 7ana 0d. Inside Cir	
28a-f sho	ector	Maryland How	ard			Jessi 10f. Zip Co					10- 6			1 🗆 Yes	٠.
"netural", or Itams 23a or 28a-f show adical Examinational be neithed at	by Funeral Director	7356 Wye Aven 11. Marital Status 1 □ Never Married 2 ☑ Ma 3 □ Widowed 4 □ Divorce	12. Was Dec	ive XNo			nt of Hisp Cuban,	2079 Danic Orig Mexican Specify:		ecify Yes or No Rican, etc.)	Un:		State - Americ k, White,	CES can Indian, etc.	
Hygiene. other than " ent, the Me	Be Completed) (1-4or 5+)	(Give life.	dent's Usual (kind of work (DO NOT use i	done dur retired) ant	ring most	r's Name	(First, Middle			siness/Ind	dustry	
and Mental Is markad of eumatic eve	ToB	Bhup 19a. Informant's Name/Relation	Singh ship (Type, Print)		19b. Mailir	ng Address (S	Street and	30	sodia sdia r or Rura	a. I Route Numb		ngh	State. Zio	Code)	_
f Health item 27 other tr		Jasody Singh/ 20a. Method of Disposition 1 Burial 2 Command Signature (3)	3 □Removal from	State ce	7356 ace of Dispo	Wye Average in the state of the	Jenu of or place)	e J	essu	p, Mar	y1ano 20c. Lo	d 207	794 City or To	wn, State	
Deportment of Importent: If any injury or ones.		21. Signature of Funeral Service	R Thomas							ome & (Crema	atory	у, Р.	Α.	
					14	411 Anı	napo	lis	Road			Mary	yland		
ıysician Medical		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	or complications that it only one cause on a		. Do not ent	411 Anı	napo	lis	Road			Mary	yland	Approximate Interval Betwoen and D	vee
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State of Maryland / Department of Health and Mental Hygien 2005 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 2005 7:0-James Robert_Smith /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c, County of Death, **Examiner** ita Roseda 65P 59110 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1₩ 2□F Director Sept 3. 2005 Maryland none Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Itam 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic avant, the Medical Exeminar must be notified at 1 ☐ Yes 2√2 No Director Cecil **Elkton** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 38 Elk Chase Drive Funeral James Robert Smit Baltimore, Maryland 21215-0036 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w h and Mental Hygier 7 te marked other th none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Heather Cullen Michael Anthony Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 end 2 sh Depertment of Health and Important: if Itam 27 ie m any injury or other traum once. Franklin Square Hospital 9000 Franklin Square Drive Rosedale, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ₩ Other (Specify) in _s∕ta⁄te 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Salvice Lucinses 21201 Baltimore, MD Approximate Interval Between Onset and Death 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. e tmmediate Cause (Final Pl Sevel eno Physician disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ate has been signed by the ettending physicien and pege 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 2 No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 2 No 1 Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide 1D Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) prive Boltimore, MD 0 Lilia Purassel onkl 000 F 31. Date filed (Month, Day, Year) 32. Registrar's Signature State foods Registrar 6 2005

20177 State of Maryland / Department of Health and Mental Hygienen O S

	Physicia		1. Decedent's Name (First, Middle, Las					2. Date of Death		3. Time of Death
				MITH				Sept.	11 2005	6:10 PM
	/Medic Examin		4a. Facility Name (If not institution, give UMVUSITY of M	e street and number)	Ctv	46. City, Town, o	r Location of Death		4c. County of Dea	th
	Funeral Director		5. Social Security Number 6. S			If Under 1 Year Months Days		8. Date of Birth (Month, Day, 1) Dec 1, 1	9. Bir (942 Mar	thplace (State or Foreign ountry) yland
ъ			Usual Residence of Decedent 10a. State 10b. County		y, Town or Lo	cation				10d. fnside City Limits
Aaryla	shov	or	MD 100. County	766. 610	Balt					1√2Yes 2□No
the	28a-	rect	10e. Street and Number		Dare	10f. Zip Code		10	g. Citizen of What C	ountry?
h with	23a or	D la	5 W. Montgomery	Street			21230		USA	
he filed within 72 hours after death with the Maryland	perfiltir. Tages it also a should be maintained and properties and second many many perfiltir. Tages it also a should be also and also a second many in the many i	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 TYes 2 TNO If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🔀 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.
P hour	natural ical Ex		15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	pation during most of work	king 1	6b. Kind of Business	/Industry
ihin 7	han 'r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	9	educatio	
1 belli	Hygie thert	e Co	12 17. Father's Name (First, Middle, Last)	5+	1	educator		e (First, Middle, M		on
and bla	ked o	To Be	Harold E. Smith	n Sr			A. Eli	zabeth So	outhwater	
or short	and N is mai		19a. Informant's Name/Relationship (Type, Print)					City or Town, State,	Zip Code)
and ;	m 27 m 27 her tr		Elizabeth A. Smit			Montgom	ery Stree		ore, MD	21230
DAILINGE,	ment of H lant: If ite lury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☑ Donation 5 ☐ Other (Special	Removat from State	emetery, crei	natory or other pla				
Dan	Depart Import any in		2. Signature of Funeral Service Licer	Wade Nirecton					Baltimore	Street
	hysician		23a. Part1. Enter the disease, or com spock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	h. Do not en	er the mode of dyir	MD 2120 ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
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= 1	5 # 1	Certifl	3 Suicide 6 Could not to 4 Homicide determined			reet, factory, office		28f. Location (Str. City or Town,	eet and Number or F , State)	nurar moute ivumber,
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical (29a. Certifier 12 Certifying P (Check only one)	hysicien: To the best of my knominer: On the basis of examination and manner stated.	owledge, deat ation and/or in	th occurred at the ti	ime, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner a ite and place, and du	is stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier SUSCIMULA 30. Name and address of person who	Bather Um	NM	29c. Licen:	se number 76435511	0628	Od. Date signed (Mor	th, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) SEP 1 6 2005

32 Registrar's Signature

			1 - For State Registrar	State of Maryla	nd / Dep	artmen rtificat	t of H	ealth ar	nd Me		ene2 ()	05	30	178
ı	Physic		1. Decedent's Name (First, Middle, La Sara Ann Schult							Date of Death Month	Day	Yeer		e of Death
	/Medi Exami		4e. Fecility Name (If not institution, gir			4b. City,	Town, or	Location of		eptembe	4c. County		5:40	O PM M
			510 Wards Road				Dow	e11			Ca1	vert		
	Funeral Director			Sex 7. Age (In yrs	. last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min.	Date of Birth (Month, Day, Y				te or Foreign
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	h the Maryland r 28a-f ahow	-	10a. State 10b. County	10c. C	city, Town or Lo	cation								City Limits
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		Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	J.S. 13.	Was Deced	dent of His	panic Origin	n? (Specify	y Yes or No- an, etc.)	14. Rece	- Ameri k, White,	can Indian	
36	hours efter tural', or its al Examine	by Fu	1 Never Married 2 Married 3 Widowed 4 XiDivorced	1 □Yes 2X No If Yes, Give Year or Dates:		1 🗆 Yes		Specify:		, 0.0.,	1	whit		
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Maryland	s 1 and 2 should be if Heelth and Mental I Itam 27 Is marked o other traumatic ava	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address	(Street a			oute Number, C			Code)	
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Baltimore,	permit. Pages. Department of timportent: If its any injury or ot once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ *4 ☒ Donation 5 ☐ Other (Special	Removal from State (y)	Place of Dispo cemetery, crer	sition (Nan natory or o	ne of ther place		Date	20	c. Location • (City or To	own, State	
Ball	Depart Import any in		21. Signature of Funeral Service Lice Ronal d S	Wader Directo	r St	ate A	d Address	of Facility my Boa MD 21	ard 6	55 W. B	altimo	re S	tree	t
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	Physici /Media		Decedent's Name (First, Middle, La Gregory L. Samuels								2. Date of D Septen		13,	2005	3. Time of Death 4:00 P M	
	Examir		4a. Facility Name (If not institution, giv 2457 Woodbrook A				46. City, Balti		Location	of Death		4c.	County	of Death		
	Funeral Director		5. Social Security Number 6. S 217-54-4782	ex 7. Age Mi 2□F	55 (In yrs. last bi	irthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of B (Month, D 05-28-1	irth 9ay, Year) 950		9. Birthpl Count Maryla	ace (State or Foreigr ry) and	
	death with the Maryland ims 23a or 28e-f ehow	ctor	10a. State 10b. County MD NA		10c. City, Tov	Oc. City, Town or Location Baltimore								10	od. Inside City Limits	
	h with the	Funeral Director	10e. Street and Number 2457 Woodbrook Avenue				10f. Zip	Code 212	17		10g. Citizen of What USA				ry?	
L 13-0030 thin 72 hours after e. e. *nature!, or ite		þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:	Ever in U.S.		Was Deced If Yes, spec		ispanic Or in, Mexica Specify:		(Specify Yes or No- erto Rican, etc.) 14. Race - Black, V Specify:					
		Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5		(Give life.	ecedent's Usual Occupation live kind of work done during most of work te. DO NOT use retired) Driver							siness/Ind		
ylasıd zı	d be filed w antal Hygier ed other ti c event, Ib	Be	17. Father's Name (First, Middle, Last)								e (First, Middle amuels	e, Maiden		king		
Mary	nd 2 should lith and Me 27 le mark r traumation	10	19a. Informant's Name/Relationship (Deseri Samuels/ Wife	Type, Print)				1020				Rural Route Number, City or Town, State, Zip				
Pages 1 en ent of Healint: If item 2 ry or other			20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Specification)	20b. Place of Disposition (N cemetery, crematory of Garrison Forest					Date 20c. Location		cation - (on - City or Town, State Mills, MD				
parimo	permit. Departm Importe any Inju		21. Signature of Funeral Service Licer		- 100	22	2. Name and	d Addre	ss of Facili	ty					MD 21217	
	nysician /Medical Examiner		23a. Part1. Enter the disease, or obm shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Atheroso	ie.	c Ca						arrest,		ĺ	Approximate Interval Between Onset and Death	
		edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence											
O. BOX 60	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral after death. To the Funeral after death. completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pre					2	23d. Date Mon	of deliver	y Day Year	
Olds, T.	equires that t ien signed by ould be detac		Part II. Other significant conditions of Diabetes, Lung di		at not resulting i	in the u	nderlying ca	tuse give	en in Part I			tobacco u Yes 2[bute to the	cause of death?	
שו שבני	hysicien: The law r his certificate has be I director, page 2 sh	Completed by									24a. Was auto perf 1 □ Yes	psy ormed?	pr de	/ere autop: nor to comeath?	sy findings available pletion of cause of	
10 10	ding Physicies h. After this certif funeral directo	tion; To Be	25. Was case referred to medical examiner? **NEXYes 2 \sum No 27. Manner of Death 1 \text{CXNetural} 5 \sum Pending 2 \sum Accident investigation	Hospital: 1 Inpatier 28a. Date of Injur (Month, Day		utpatier Time of Injury		Bc. Injun	er: 4□Nu	ursing Ho	n (Check only me 5 ☐ Res 28d. Describe	idence 6			at scene	
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		iry - At home, fa . (Specify)	arm, str			. 55 2		28f. Location City or To	Street and wn, State	d Numbe)	r or Rural	Route Number,	
	the Hospi nin 24 hour the Funera npletely fille	Medical (one)	ysician: To the best on niner: On the basis of and manner sta	examination ar	e, death	vestigation,	in my op	oinion, dea	d place, a	and due to the ed at the time	date and	place, a	nd due to t	he cause(s)	
	6 3 ¥ 5 9	2	29b. Signature and title of certifier					.C.M	·E.					(Month, D		

State Registrar

Ana Rubio, MD 31. Date filed (Month, Day, Year)

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

			1 - For State Registrar	State of Maryland		artment of tificate o		nd Mer		2º00	5	301	80
	Physici	an	1. Decedent's Name (First, Middle, Last AGNES DE LOW		East			2.	Date of Death Month	Day	Year	3. Time o	f Death
	/Medio		4a. Facility Name (If not institution, give		0.0	4b. City, Town	n, or Location of D	Death	7	4c. County	of Death	DIE	
7 (5.		89- Y	5. Social Security Number 6. S	PICE 7. Age (In yrs. ii	ast hirthday)	10WSO	ar If Under 24	Hrs. a	Date of Birth	BA	-/1	no RE	or Foreign
<u> </u>	Funeral Director		216-26-1063	□M 22(F 73	Yrs.	Months Day			(Month, Day,)	'ear)	MA	place (State Intry)	VD
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation						10d. Inside C	ity Limits
	h the Maryland rr 28a-f show	ctor	MD,	BA	Tim	ORE					:	1 Yes	2 No
	death with the Maryland ms 23a or 28a-f show rmust be notified at	Funeral Director	10e. Street and Number	NORE STREE	T	10f. Zip Code	1274		109	Citizen of	What Cou	untry?	
	death	neral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. \	Vas Decedent of	of Hispanic Origin uban, Mexican, P	? (Specify	Yes or No-			ican fndian,	
36	be filed within 72 hours after death with Hygiene. d other than "natural," or items 23e or event, the Madical Examiner must be	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		I □ Yes 200		ubito i tica	111, 610.)	Specify	ck. White	Arr	
15-0036	72 hou natura	eted	15. Decedent's Ed	ducation	16a. Deced	lent's Usual Occ	cupation ne during most of	f workin a	16	b. Kind of B	usiness/li	ndustry	
121	filed within 72 Hygiene. ther then "net int, the Medic	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use ret		Working		SVI	nnl		
א פר	be filed tal Hygi d other event,	Be Co	17. Father's Name (First, Middle, Last)	0	12.70	1000	*	Name (F	irst, Middle, Ma	iden Suman	18)		
ylan	should being Ments marked marked	To	HEZEKIAH	CATOR	T		Non	HE	6 RE	60Ry			
Mary	12 7 18		19a. Informant's Name/Relationship	RN70N	729	Address (Sine	eet and Number o	or Rural Re	oute Number, (0		ip Code) ID, 21,	205
o ē	一ゴる中		20a. Method of Disposition 1 Burial 2 Cremation 3	20b. Pl	ametery, cren	sition (Name of natory or other p	olace)	Date		c. Location -	City or T	own, State	
Baltimore,	Parity A		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	V) CKO	WNSVI	le Name and Add	drace of Eachby	-19-	05 C	POWNS	vil	le N	ID,
n m	permit. Departri Imports any inju		Ohills A	Weather		4/LLIP -431 E	dress of Facility A. WEAT T. OLIVE	THER R ST	FORD BA	FUNE	RAL ND,	212	13
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	n. Do not ent	er the mode of o	tying, such as car	rdiac or re	spiratory arres	t,		Approximatinterval Bet Onset and	te ween
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Metas tatio		st Cau	ncer					mon Pa	
	Examiner		Sequentially list conditions,	b	dence or).								
	ted nsit	nlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience of):								
oʻ	icate be executed physicien and s the burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a consequ	ience of):								
98/60	physicist the but	dical		_ d									
XOR	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar		Ectopic pregna	500			23d. Dai	te of deliv	very	
o D	the death certificate be executed y the attending physicien and tched for use as the burial-transit	Physiclan/Me	in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	4☐Pregnant at time of de 9☐Unknown		Other (specify)				Мо	nth	Day	Year
ב	res that the de signed by the a be detached f	by Ph	Part If. Dther significant conditions of	ontributing to death but not resu	ılting in the ur	nderlying cause	given in Part I.		23e. Did toba	cco use cont	ribute to	the cause of c	death?
ords	w require been sig should b	ted t						_	1 ☐ Yes	2 🗆 No	3 Pro	bably 4 🔀	Jnknown
Hecords,	m vs or	Completed							24a. Was an autopsy performe	a ? (geath?	opsy findings empletion of c	available ause of
_		Be Co	25. Was case referred to medical				26. Place of	Death (Ci	1 ☐ Yes 2 ☐	Mo 1	□Yes	2 No	
>	this ald	은	examiner? 1 Yes 2 No		ER/Outpatien	3 DOA			5 Residence			my Hospic	c
0	nding I th. : After e funer	atlon	27. Manner of Death 1. ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. In W M 1	ijuryat Vork? □Yes 2 □No	28d.	Describe how	injury occurr	ed		
Division	al or Attendis atter death. I Director: Al d in by the fu	Certification:	3 Suicide 6 Could not be determined	e 28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office	Э	28f.	Location (Stree City or Town,		er or Run	al Route Num	ber,
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Ph	ysician: To the best of my know	wledge, death	occurred at the	time, date and p	lace, and	due to the cau	se(s) and ma	nner as :	stated	
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	one) 2 Medical Exam	niner: On the basis of examinat and manner stated.	ion and/or inv	estigation, in m	y opinion, death o	occurred a	t the time, date	and place, a	and due t	to the cause(s	;)
	Veit To To	2	29b. Signature and title of certifier	e mp			onse number 06/199			Date signed			
11	or		30. Name and address of person who	completed cause of death (Item	23a) (Type, I	Print)				1 1			
4	No.	-	Jason Black	, 660 2 Way	Pa Che	ad kes	Pouson	r h	10 2	204			
**************************************	Sta Registr		31. Date filed SEP , 1 ay, 6 2005	Page 1	Sec.	W				(

			1 - State of Maryla		irtment of tificate of		_	giene Reg. No. 0 5	30181
	D		Decedent's Name (First, Middle, Last)				2. Date of De Month	path Day Year	3. Time of Death
	Physici /Medic		Charles Edward	rustr	7		0	9 12 0.	
Ž	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town,			4c. County of De	
			BALTIMURE VA MEDICAL COM	ter trimbulant	If Under 1 Yea	mure		-	
	Funeral Director		5. Social Security Number 6. Sex 1 № M 2 □ F 7.4 Age (In yr	s. last birthday) Yrs.	Months Day		Min. (Month, Da	ay , $Y \Theta ar$) (irthplace (State or Foreign Country) IARYLAND
			Usual Residence of Decedent	<u>. </u>			Sept.	12, 1954 F.	IANTUAND
	show ad at		10a. State 10b. County 10c. (City, Town or Lo	cation				10d. Inside City Limits
	Ba-f s	cto	MD ANNE ARUNDEL	GLEN	BURNIE				1 ☐ Yes 2 ☐ No
	or 2	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What (Country?
	s 238	rai	6571 Booker Ave. 11 Marital Status 12. Was Decedent Ever in	110 110 1		060	in2 (Canada Van an Na	U.S.A.	nerican Indian,
	Item Iner	Funeral	Armed Forces?	0.5. 13. V	Yes, specify Cu	iban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	Black, Wh	
920	urs al	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Give Year or Dates: 1952	2-1953	☐ Yes 2⊠ N	o Specify:		Specify:	BLACK
21215-0036	within 72 hours after death with fhe Maryland ane. then "natural", or Items 23a or 28a-f show ta Madical Examinat must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a, Deced	lent's Usual Occi	upation	of working	16b. Kind of Busines	
21	ithin de Me	npie	Elementary/Secondary (0-12) College (1-4or 5+)	life. E	OO NOT use retir	red)	er wearing		
	fygier fygier her tl		12th	MAINTE	NCE	19 Mothor	's Name (First, Middle	GENERAL EI	ECTRIC
Maryland	s 1 and 2 should be filed within 72 hours after death with fhe Maryla f Health and Mental Hyglene. Item 27 Is marked other then "natural", or Items 23a or 28a-f shov other treumatic event, It a Medical Examinar must be notified at	Be c	WILLIAM TRUSTY SR.				SE LEE BROV		
Z	should bd Me mark mati	입	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Stree			er, City or Town, State,	, Zip Code)
	1 and 2 Health a tem 27 is		WILLIAM TRUSTY/BROTHER	214 C	ONEWOOD	ROAD I	REISTERTOWN	N, MD 21136	5
J.	ges 1 and t of Health If item 27 or other tr		20a. Method of Disposition 20b 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Place of Dispos	sition (Name of natory or other pi	lace)	Date	20c. Location - City of	or Town, State
ij	Pages nent of I ant: If its ury or o			EDAR HIL	L CEMET	ERY 9-	-17-2005	GLEN BURNI	E, MD
Baltimore,	permit. Pages Department of H Important: If its any injury or of		21. Signature of Funeral Service Licensee	W1	Name and Add	ress of Facility Brown	n Comm. Fur	neral HOme	P.A.
	0.0 = € 0		Delloan 9	12	206 W. N	orth Av	ve. Baltimo	ore, Md 212	217
d.			234. Part1. Enter the disease, in complications that caused the de shock, or heart failure. Lost only one cause on each line.		_	-			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	jan ta	ulure	inclucli	ng FICUTE	REspirato	My
	Examiner		immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Each Indehving. Due to (or as a considerate cause. Each Indehving.	Jun de	one.	Ren	al Saim	re	10 days
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	equence of):			<u> </u>		7
	cuted nd ransit	Examiner	that initiated events c.		OCK				
90	ficate be executed physician and s the burial-fransit	Ē	resulting in death) Last Due to (or as a const	equence of):					
8760,	cate b	dicai	d						
9 x	The law requires that the death certificate be executed tee has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Completed by Physician/Me	IF FEMALE: 23c. If yes, outcome of preg	nancy			110	23d. Date of d	elivery
Вох	death atter	ciar	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnan Other (specify)	icy Λ	//A	Month /	Day Year
0	that fhe ded by the detached	hysi	1 Yes No 9 Unknown 9 Unknown				•	N	14
S, D	res that signed to be deta	by P	Part II. Other significant conditions contributing to death but not r	-				tobacco use contribute	to the cause of death?
ord	w require been si should I	ted	Congestive Heart Jain	we	and		11	Yes 2 No 3□F	Probably 4 ☐Unknown
Records,	hasbe ge 2 sh	npie	Congestive Heart fail Atrial fishillation; Che	Waic	OBS Mu	ctive	24a. Was	psy prior to	autopsy findings available completion of cause of
E	cate to		pulmonary disease				pend 1 ☐ Yes	ormed? death? 2 No 1 Ye	es 2 No
Vital	Physicien: The this certificate ral director, page	Be	25. Was case referred to med axaminer? Hospital Inpatient 2				of Death (Check only o		
of	Phys r this ral di	1: To	27. Manner of Death 28a. Date of Injury	ER/Outpatient 28b. Time of	28c. lnj	ury at		dence 6 Other (Sp	ecify)
on	th. :: After e funer	atlor	Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	W	'ork? ⊒Yes 2 ⊒ N	lo		
Division	Atternation of the part of the	tifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spe	home, farm, stre	eet, factory, office	9	28f. Location (Street and Number or I	Rural Route Number,
ā	ital or rs after rel Dir led in	Certification;					4		
	To the Hospital or Atlending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medicai	29a. Certifier (Check only (Ch	nowledge, death nation and/or inv	occurred at the restigation, in my	time, date and opinion, death	I place, and due to the n occurred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	thin 2 the othe	Med	one) and manner stated. 29b. Signature and title of certifier		29c. Lice	nse number		29d. Date signed (Mor	nth, Day, Year)
	8 4 € 4		Melangaciane M	d	10	6774	/	na/	2005
	اسلس	+	30. Name and address of person who completed cause of death (III						
	1211		DIANA CARAGACIANY M.) 10 M	Green.	e 57.	Baltimore	MD 2120	2/
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Sig	nature	ا د				
	Regist	dl 	SEP 1 6 2005 Seems 1	4004					

			1 - For State Registrar	State of Maryland / Dep	artment of Health and I			5 30182
			Decedent's Name (First, Middle, Las		ranoato or beatin	2. Date of Deat		3. Time of Death
	Physici		Ronand	Tenny		Month 9	Day	Year 05 11 30 p M
	/Medi Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of	
			BonseLours	Hospital	BALTIMORE			NA
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last birthday		8. Date of Birth		Birthplace (State or Foreign Country)
-	Director		018-13-6011	M 2 F 48 Yrs.	World Buys Hours Will.	8. Date of Birth (Month, Day, 02.23.	1957	MD
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	Aaryli sho	o	MD NA	BALTIMOR				1 No 2 No
	28a-	Director	10e. Street and Number	PALITION	10f. Zip Code	1	0g. Citizen of W	hat Country?
	ours after death with the Maryland relf, or Items 23e or 28a-1 show Examiner must be notified at	0	2911 WALBROOK A	AVEADIE	21216	'	_	SA
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S)	pecify Yes or No-		- American Indian,
ယ္	fter rite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 Ø No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)		x, White, etc.
03	hours after urel', or ite	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 PNo Specify:		Specify:	BLACK
5-0036	72 h	Completed	15. Decedent's Ed (Specify only highest grad	de completed) (Give	dent's Usual Occupation a kind of work done during most of work	kina	16b. Kind of Bus	siness/Industry
2121	Athln han.	du	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)			
	lled w lygie her tl		911 GRADE 17. Father's Name (First, Middle, Last)	N/A LA	BORER		LANDSC	
anc	hall Hall Hall Hall Hall Hall	Be	DAVID S. TERRY		HELENA	e (First, Middle, M	Maiden Sumame)
Maryland	ges 1 and 2 should be filed within 72 hours a to f Health and Mental Hygiene. If item 27 is marked other than "naturel", or other treumetic event. It is Madical Example.	은	19a. Informant's Name/Relationship (T	ivne Print) 19h Mail	ing Address (Street and Number or Ru		City of Town 6	State Zie Code l
Ma	nd 2 satth an 27 is r treu		HELENA A. TERRY		WALBROOK AVE.		-	·
ē,	Heal Heal tem 2		20a. Method of Disposition	20b. Place of Disp	osition (Name of	Date :	20c. Location - C	City or Town, State
J0	ages ant of nt: If i		1 Burial 2 Cremation 3 □I 1 Donation 5 □ Other (Specify,	Hemoval from State	matory or other place)			STO WN, MD
Baltimore,	permit. Pages 1 ar Department of Hea Importent: If item eny injury or other once.		21. Signature of Funeral Service Licens	200	O Name and Address of Facility			-
ñ	Depa Depa Impo eny ir		Daughn C	T Y	AUGHN C. GREENE 151 BALTO. NATL PIKE	FUNERAL	SERVICE MA 212	วิกล
*	•		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. Do not en	ter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	netastatic	Times Disea	L1 10		Onset and Death
1	/Medical		resulting in death)	a Due to (or as a consequence of):				
8	Examiner		Sequentially list conditions,	Daute Ren	al failure			
	₽ ≒	iner	f any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of).				
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Lucy C	whosis			
8760,	cate be executed obly sician and the burial-transit			Due to (or as a consequence of):	4			
87	requires that the death certificate be execu een signed by the attending physician and hould be detached for use as the burial-tran	dlcal		d	3			
9 X	certifi ding se as	/Me	IF FEMALE:	23c. If yes, outcome of pregnancy			224 2	
Вох	leath certific attending p	clan	in the past 12 months?	1 Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date Mont	
P.O.	that the de led by the a detached t	Physiclan/Me	1 Tes 2 No 9 Unknown	9□ Unknown				
	res that signed b be deta	y PI	Part II. Other significant conditions co	intributing to death but not resulting in the c	inderlying cause given in Part I.	23e. Did tob	acco use contrib	oute to the cause of death?
rds	w requires been sig should b	od be				1 □ Ye	s 2 □ No 3	Probably 4 Unknown
၀၀	> 0 8	plet				24a. Was ar	1 24b. W	ere autopsy findings available
Vital Records,		Completed by				autopsy perform	ned? de	or to completion of cause of ath? □ Yes 2★ No
ital	ien: rtifica ctor, p	Be C	25. Was case referred to medical		26. Place of Deal	h (Check only one		2/03 2/2/110
>	Physicien: r this certific ral director,	To	examiner? 1 ☐ Yes 2 🕵 No	Hospital: 1 🗖 Inpatient 2 🗆 ER/Outpatie	nt 3 DOA Other: 4 Nursing Ho	me 5 Resider	nce 6 Other	(Specify)
0	ding PI N. After ti funera	:uo	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury 28b. Time of (Month, Day Year) Injury	f 28c. Injury at Work?	28d. Describe ho	w injury occurred	d
sio	Attendir death. ctor: Ai y the fu	catl	2 Accident investigation 3 Suicide 6 Could not be		M 1 ☐ Yes 2 ☐ No			
Division of	or At Ifter d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Str. City or Town,	reet and Number , State)	or Rural Route Number,
	pitel ours a erel [29a. Certifier 12 - Certifying Phy	picien. To the best of au leasulades dest				
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the tuneral director, page	Medical	(Check only 2 Medical Exemi	sician: To the best of my knowledge, deat iner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the ca red at the time, da	use(s) and manr ite and place, an	ner as stated. d due to the cause(s)
	o the	Me	29b. Signature and title of certifier		29c. License number	29	d. Date signed ((Month, Day, Year)
	- s + ō		DAY	SICIAN	057543		9-13	
	14		30. Name and address of person who co	ompleted cause of death (Item 23a) (Type,	Print)			
	4		P. SANDHU MD	1940. W. BALT, 32 Registrar's Signature	MORE ST R	ACTIM	ORE	MD 21227
	Sta		31. Date filed (Month, Day, Year)	32/Registrar's Signature	West of the second		1	
	Registr	ar	SEP 1 6 200	15 Della Se La				

State of Maryland / Department of Health and Mental Hygien 0 5 30183 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Year 1633 3,2005 William Thompson , Sr. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore NA Union Mem. Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Another Service Another Servi 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1√ M 2□ F Director 217-40-9008 Usual Residence of Decedent with the Maryland 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits 28e-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Directo Baltimore Md. NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Items 23a 21218 USA 619 E. 41st Street Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. int: If Item 27 Is marked other than "naturel", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Mt. Vernon Hosp. 12th grade Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alice R. Thompson Gresham Robert Lee 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 619 E. 41st Street, Baltimore, Md. 21218 Nancy L. Thompson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Garrison Forest Vet.9-19-05 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Md. 21202 Baltimore, ladys March F.H. East 1101 E. North Ave. Warn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ncterenia 6 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Siscose frany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner executed transit Due to (or as a consequence of): burialthe attending physicien and for use as the burial Box 68760 The law requires that the death certificate be Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, pe 1 Yes 2 No 3 Probably 4 Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 ☐ Yes 2 ☐ No 2 No Division of Vital the Hospitel or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 V No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After thi funeral of 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 29a, Certifier 1 📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Unian Memorial Hosp 215 E. Univ. PKWY, Baltimore ND 21218 Tamischer BNEHLES MC 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 1 6 2005 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie 26 0 5

		For State Registrar	(First Middle I a			nd / Depa <i>Cei</i>			Death	1	2. Date of De	Reg. N			3. Time of Death
hysiciar /Medica	n il	STEPH	EN PRES	TON TURN							Month	D	ay Ye 13, 20	oar 005	10:45 p ^M
xamine	_	4a. Facility Name <i>(II</i> 309 9th S		e street and numbe	ər)			,Town,o aurel	Location o	of Death			c.County of [Prince		rae's
neral ector		5. Social Security N 218-56-83		ex 7 ∑	Age (In yrs	. last birthday) Yrs.	If Und Months	or 1 Year Days	If Under Hours	Min.			9. Birthplace (ace (State or Foreign
A III	h	Usual Residence of 10a. State	Decedent 10b. County		10c. C	ity, Town or Lo	cation							10	d. Inside City Limits
aumatic event, the Madical Examiner must be nutified at To Be Completed by Fundament Director	200	MD	Prince G	eorge's	L	aurel									1∏Yes 2∏No
niner must be notified	DIE	10e. Street and Nun						ip Code				10g. C	itizen of Wha	Count	try?
Trust	era	11. Marital Status	orreer	12. Was Decede	nt Ever in I	J.S. 13. V		2070		ain? (Spe	cify Yes or No		U.S.A. 14. Race · A	merica	an Indian
by Fire	2		ed 2 Married	Armed Force 1 ☐ Yes 2 ☐ If Yes, Give Year or Date:	OMO			ecify Cuba 2 X ∭No	n, Mexican	i, Puèrto F	cify Yes or No Rican, etc.)		Specify:	Vhite, e	tc.
Completed	paraidi	Elementary/Secon	15. Decedent's Edity only highest grandary (0-12)	ducation ade completed) College (1-4c	or 5+)	16a. Deced (Give life. 1 Super	lent's Usi kind of w DO NOT VISO	ual Occupa ork done o use retired	ation furing most	t of workin	g	16b. F	Kind of Busine	ess/Ind	ustry
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TO Be	0	Laudis Tu								rs Name a Har	(First, Middle	, Maidei	n Sumame)		
- L		19a. Informant's Na	me/Relationship (Type, Print)		19b. Mailin	g Addres	s (Street a				er, City	or Town, Stat	e, Zip (Code)
other traumatic	-	Kathryn I		daughte				Stree			, Mary	land	2070	7	
- 11			☐Cremation 3 ☐	Removal from Sta	ro l	Place of Dispos			1		ate		ocation · City		
SUCE	ŀ	* 4 ☐ Donation 21. Signature of Fur	5 ☐ Other (Specification of Service Licer		1 77	y Hill		_		9/17/ v		La	aurel,	Mar	yland
SIG		Laui	u Nan	rella MC	0160	Do	onal 13 T	dson albot	Funer t Ave	al H enue	ome, P Laure	.A. 1, M	Marylar	nd	20707
ān -		23a. Part1. Enter the shock, or hear Immediate Cause (I disease or condition	Final			th. Do not ente	or the mo	de of dying	g, such as	cardiac or	respiratory a	rrest,			Approximate Interval Between Onset and Death
cal		resulting in death)	-	Due to (or a			all	CCII	Hullg	Can				1	3 months
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Examiner		Cause (Disease or i that initiated events	njury		13 4 00/130/	quence on.									
		resulting in death) L	ast	Due to (or a	is a conse	quence of):									
/Medical		IF FEMALE:		23c. If yes, outcom	ne of prean	ancv						П			
Physician/M	lysicial	23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	aldeath 3□	Ectopic p Other (s	regnancy pecify)					23d. Date of Month		/)ay Year
3	5 '	Part II. Other signific Polio	cant conditions o	ontributing to death	but not res	sulting in the un	derlying	cause give	n in Part I.						cause of death?
age 2 should be a											24a. Was	an	24b. Were	autops	sy findings available
Compl	5											rmed? 2⊠No	death	o comp	sy findings available pletion of cause of XNo
Be	2	25. Was case referre	- T	Hospital:				011			Check on o	ne)			
		1 ☐ Yes 2 🔀 27. Manner of Death	+0	1 ☐ Inpa 28a. Date of In (Month, D		ER/Outpatient 28b. Time of		OA Othe	4 □ Nur	sing Home	e 5 XX Resid ld. Describe h	lence low iniu	6 □Other (Si	pecify)	
atlon:		 Matural Accident 	5 Pending investigation		lay Year)	Injury	М	28c. Injury Work 1 🗌 Y	? es 2 □ N			,,	,		
Certificat		3 Suicide 4 Homicide	6 Could not be determined	28e. Place of I	njury - At h etc. <i>(Speci</i>	ome, farm, stre	et, factor	y, office		28	of. Location (S City or Tow	Street an m, State	nd Number or	Rural I	Route Number,
edical		29a. Certifier (Check only one)	1X Certifying Ph 2☐ Medical Exam	ysician: To the bes niner: On the basis and manners	of examina	owledge, death ation and/or inve	occurred estigation	at the time, in my op	e, date and inion, death	place, an	d due to the d at the time, d	cause(s) date and) and manner d place, and d	as stat ue to ti	ed. ne cause(s)
Medical Certifica		29b. Signature and	itle of certifier	m			29	c. License	number			29d. Dat	te signed (Mo	nth, Da	ay, Year)
D			176/8	11/	1		-	D 2	5422			Sept	ember	15,	2005
YD	1	30. Name and addre Robert	ss of person who d Maggin , I			n 23a) (Type, P ltimore		nuc	T 2225	01 :	/n w - 1 -		20727		
State	:	31. Date filed (Month		32. R	trar's Signa	ature	and!		Laul	CI, I	Marylar	ıu	20707		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death THOMPSON **Physician** Year /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner University Hospital Baltimore NA If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 215-40-400 Usual Residence of Decedent 1**X**M 2□ F 61 Director Yrs Maryland with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other fraumatic event. The Mudical Experience must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD NA Baltimore 1X Yes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 524 Rossiter Ave USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: δ 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stacey R. Thompson Bessie Tibbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shauntay Thompson/Daughter 2817 Denham Circle Baltimore, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 9-16-05 Catonsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jones Wylie Funeral Home P.A. 638 N. Gilmor St. Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Privsician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit opmo - me that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day signed by the at d be detached fo 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 No 2 No 1 Yes 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pendina s after death, 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 09-13-05 30. Name and add s of person who completed cause of death (Item 23a) (Type, Print) Sheet South charles 60 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State SEP 1 6 2005 Registrar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

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			For State Registrar	State of Maryland / Depa	artment of Health and rtificate of Death		jier 2º 005 3	30187
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Robert Craig Webste	Yr		2. Date of Dear Month		3. Time of Death 9:32 a. M
	Examin		4a. Facility Name (If not institution, give st	treet and number)	4b. City, Town, or Location of Dea		4c. County of Death	
			100 Revolution Str	7. Age (In yrs. last birthday)	Havre de Grace		Harford	(C1-1
	Funeral Director		225-70-4751	M 2□F 57 Yrs.	Months Days Hours Mir		Year) S. Binnplac Country 948 Virgi	ce (State or Foreign v) Núa
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		100	1. Inside City Limits
	a-fsh	ctor	MD Harford	Havre de G	race			1 X Yes 2 □ No
	vith th	by Funeral Director	10e. Street and Number		10f. Zip Code	1	0g. Citizen of What Country	y?
	eath v	eral	100 Revolution St., 11. Marital Status		21078 Was Decedent of Hispanic Origin? (Specify Ves or No-	USA 14. Race - American	Indian
(0	r kem	Fun	1 Never Married 2 Married	1 TYYes 2 □ No	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	rto Rican, etc.)	Black, White, etc	c.
<u>ල</u>	ural', c	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates 1969-71	1 ☐ Yes 2/☐ No Specify:		Specify: White	e
21215-0036	s 1 end 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or iteme 23a or 28a-1 show other traumatic event, the Madical Examinar must be notified at	Completed	15. Decedent's Educ (Specify onfy highest grade Elementary/Secondary (0-12)	completed) (Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	orking	16b. Kind of Business/Indus	stry
2	filed will Hygien other th		17. Father's Name (First, Middle, Last)	4 Years D	isabled	ma (First Adiddle)	Maidan Sumama)	
Maryland	d be fi	To Be	Robert W. Webster			_{lme (First, Middle, 1} d Jourdan		
ary	2 should be and Mental Is marked o	-	19a. Informant's Name/Relationship (Typ	ne, Print) 19b. Maili	ng Address (Street and Number or F			'ode)
	l end 2 tealth a m 27 ls		Karen Wright-Siste		Armour Ct., Haymo			
200	Pages 1 nent of H ent: If Ite ury or ott		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	inovaliioni State	esition (Name of matory or other place)		20c. Location - City or Town	
Baltimore,	permit. Pages 1 en Department of Heal Importent: If Item 2 eny Injury or other ance.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	R.A. Ferr	US & CO. (U9/)	02/2005	West Chester,	, PA
ä	permit. Departr Importe eny Inj		studine m	. Someto 12	2. Name and Address of Facility. itchell-Smith Ful 3 S. Washington,	ieral Hom Havre de	Grace, MD 21	1078
			shock, or heart failure. List only one	ations that caused the death. Do not enter a cause on a sch line.	er the mode of dying, such as cardia	c or respiratory arre	est, A	pproximate iterval Between Onset and Death
	Fnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	ardiora, co	en Vis	ease	
	Examiner		Conversion has a conditions	Due to (or as a consequence or).				
	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
	te be executed ysicien end ie burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence of):				
1760,	ysicier		L d.					
k 68	ertifica ling ph e as th	Med	IF FEMALE:		the grant and a second a second and a second a second and			
Box	w requires that the death certificat been signed by the attending phy should be detached for use as th	Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Da	
P. 0.	hat lhe od by th	Phy	9 ☐ Unknown Part II. Other significant conditions cont		nderlying cause given in Part I	23e. Did tob	pacco use contribute to the	cause of death?
Division of Vital Records,	quires on sign	ed by	Virhetes 1	rellitus		1 □ Y€	es 2□No 3□Probab	ly 4 Unknown
eco	law re as bee	piet				24a. Was a autops		y findings available eletion of cause of
<u>e</u>	i: The					, perform	ned? deal!?	□ No
5	siciar s certif lirecto	o Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	ospital: 1 Inpatient 2 ER/Outpatier	Other	eath Check only on	ence 6 XOther (Specify)	At scene
10	g Phy ter this neral d	n; To	27. Mannes of Death	28a. Date of Injury (Month, Day Year) 28b. Time o			ow injury occurred	At Scelle
sior	tendin leath. tor: Af	catio	Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No			
<u>S</u>	efter definition of the defini	Certification;	4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (St. City or Town	reet and Number or Rural R n, State)	Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death. To the Funeral Director: After this certificate has been signed by the attending physicien end completely illied in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier 1 Certifying Physical Check only on the Control of	ician: To the best of my knowledge, deat er: On the basis of examination and/or in and manner stated.	h occurred at the time, date and plac vestigation, in my opinion, death occ	e, and due to the ca urred at the time, da	ause(s) and manner as state ate and place, and due to th	ed. ne cause(s)
	To th withir To th	Me	29b. Signature and title of certifier	\bigcap	29c. License number OCME		9d. Date signed (Month, Da eptember 2, 2	
7	Kny		30. Name and address of person who cor	npleted cause of death (Item 23a) (Type.	Print), D. C.			
	101		J- LARON Coc	KEIND	111 Penn Street	Baltimor	e, Maryland 2	21201
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signature	t, s			
DH	MH 17 Rev 1/2		SEP 1 6 2005	Siene It Span				

Physicia /Medica Examine

Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Importent: If Item 27 le marked other than "neture!', or Items 23a or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

3	Williams Please Ty	pe or Print in Black	k Indelible Ink.	Ensure All	Copies Ar	e Legible.	
	1. State Unpend Item 23	State of Maryland / D a , 27 , 28a – f per i	Department of H Ceffile at 1573	ealth and M eath tas	ental Hygier	2005	30188
	Decedent's Name (First, Middle, Last) CHATINKA MARI	IA WILLIAMS				Day Year r 12, 2005	3. Time of Death 8:27 A M
	4a. Facility Name (If not institution, give str Johns Hopkins Ho	spital	4b. City, Town, or Baltimo	re	_	4c. County of Death N/A	
	5. Social Security Number 213-86-9733 Usual Residence of Decedent	7. Age (In yrs. last birt	trunder 1 Year Months Days Yrs.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea 10/26/1	9. Birthpla Count 974 MAR	ace (State or Foreign ry) YLAND
0100	10a. State 10b. County MD N/A	10c. City, Town	n or Location BALTIMORE	CITY		10	d. tnside City Limits 1 Yes 2 No
ruiciai Diic	10e. Street and Number 249 ST. MATTHE	EWS STREET	10f. Zip Code 2120		U	Citizen of What Count	ry?
2	11. Maritat Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 21 No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - America Black, White, e	tc.
combiered	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0·12) 1 0 T H	ation 16a. College (1-4or 5+)	Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired COOK	uring most of working	ng	Kind of Business/Ind	CORP.
ים פפים	17. Father's Name (First, Middle, Last) RUDOLPH WILLIAM	1S		18. Mother's Name	(First, Middle, Maid	en Sumame)	
	19a. Informant's Name/Relationship (Type SHAWNDA SMITH /		Mailing Address (Street a 418 LOYOLA				
	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	mousi from State cometer	Disposition (Name of ry, crematory or other place ZION CEM.	9/20)/05 B	Location - City or Tov	CO., MD
	21. Signature of Juneral Service Licenses	8. Raves		ERTY HEI	GHTS AV		E 21207 IMORE, MD
al Lyalling	Immediate Cause (Final	Ocaine associate Due to (or as a consequence of Due to (or as	ed agitated of:				Approximate Interval Between Onset and Death Iggle
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. tf yes, outcome of pregnancy 1 Live birth 2 Fetat death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deliver Month	y Day Year
	Part tl. Other significant conditions cont	ributing to death but not resulting in	n the underlying cause give	n in Part I.	23e. Did tobacc	o use contribute to the	
combiered by					24a. Was an autopsy performed'	death?	sy findings available inpletion of cause of
2	25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No	spitat: 1 ☐ Inpatient 2 🗷 ER/Ou	other 30 DOA Other	26. Place of Death	*		
Callonia - O	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 M Could not be	28a. Date of Injury 9-(1/21/10/39' Year) found 28b. 1 7:2 found	Time of 28c. Injury Work	at ? 'es 2 XNo	28d. Describe how in		nk
medical cel illication;	4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify) basement			Baltimore.	and Number of Rural ate) 1604 Lati Maryland	
יבחונים	(Check only amelian (Check only one)	cien: To the best of my knowledge er: On the basis of examination an and manner stated.	d/or investigation, in my of	inion, death occurre	ed at the time, date a	and place, and due to	the cause(s)
4	29b. Signature and title of certifier	· X of our	29c. License 0.C.			tember 13,	
	30. Name and address of person who con		(Type, Print) 11 Pann Stra	ot Rolti	more Mar	viland 212	∩1

State

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate hes been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year)

32. Pegistrar's Signature

SEP 1 6 2005

Registrar

	1- For State of Maryland / Department Certificate	nt of Health and Mental Hygiene 2005 30189
Physician	Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year
/Medical	FRANCES A. Wise 4a. Facility Name (If not institution, give street and number) 4b. City,	Town, or Location of Death Town, or Location of Death
Examiner	6727 Throway	Dundalk
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under A 15 - 40 -0750 1 M 2 F	
ehow	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
death with the Maryland ms 23a or 28a-1 show roust be notified at near all Director	Md. Dundalk	1 No 2 □ No
of the state of th	10e. Street and Number 10f. Zip	2 / 2 2 2 10g. Citizen of What Country?
ter death w items 23a iner crusti	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent	dent of Hispanic Origin? (Specify Yes or No-
036 urs after all, or ite	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	crify Cuban, Mexican, Puèrio Rican, etc.) Black, White, etc. Deno Specify: Specify:
ind 21215-0036 be filed within 72 hours after tall Hygiene. alo other than "natural; or its event, the Madical Examine Be Completed by Fu	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usua	al Occupation 16b. Kind of Business/Industry
21215-00 ed within 72 hou yajenn 72 hou yaje	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+) (Give kind of wor life. DO NOT us	
121 lied wi tygien ther th	12 th NU.	18. Mother's Name (First, Middle, Maiden Sumame)
/land uid be fil wental H wrked out	1.11. + - 1.11	Alynne shifflet
and Is me	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	s (Street and Number or Rural Route Number, City or Town, State, Zip Code)
iore, M ges 1 and 2 ti of Health if Item 27 i	Debra Keene Daughter Soft 20a. Method of Disposition 20b. Place of Disposition (Nan	
0 0	cemetery, crematory or or	other place)
Baltimo	21. Signature of Funeral Service Licenses 22. Name an	Cemeter/7-9-05 FINKSburg Mc.
Bal permi mpo mpo any ii	way yaves 20	OF EASTERN AVE. BALIO.MA. 21231
and the second	23a. Part1. Enter the disease, or complications of at caused the death. Do not enter the mod shock, or heart failure. List only one cause on each line.	de of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death
Pnysician / /Medical	Immediate Cause (Final disease or condition resulting in death) a. Due to (or s a consequence of):	taxatic tobrain months.
Examiner		
iner liner		
executed executed in and ial-transit	that initiated events resulting in death) Last C. Due to (or as a consequence of):	
MC. S8760, Icate be executed physician and s the burial-transit	d	
c 68 antifica ing ph	IF FEMALE:	
1) THE / HH DL T 11 Records, P.O. Box 68 12 The law requires that the death certificate has been signed by the attending phone as a sequence 2 should be detached for use as the completed by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Use birth 2 Fetal death 3 Ectopic pr. 4 Pregnant at time of death 5 Other (sp.	
P.O. B. that the death that the death of for detached for Physicia	1 Tes 2 2 No 9 Unknown 9 Unknown	Assiry,
S, P.(es that the gned by be detac by Ph)	Part II. Other significant conditions contributing to death but not resulting in the underlying contributions.	
Records, ne law requires has been signings 2 should be	Tobacco abuse	1 Ryes 2 No 3 Probably 4 Unknown
Rec Belaw ne law shas b ge 2 s		24a. Was an autopsy findings available prior to completion of cause of death?
	25. Was case referred to medical	1 Yes 2 No 1 Yes 2 No
of Vita of Vita Physician: this certific ral director,	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DO	
On Con Con Con Con Con Con Con Con Con Co	27. Manner of Death 1. Natural 5 Pending (Month, Day Year) 28b. Time of Injury (Month, Day Year) M	28c. Injury at 28d. Describe how injury occurred Work? 1 □ Yes 2 □ No
Division of Attence after death Director: Jin by the ertificat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)	
Division of Division of the lot Attending Parallel death. All of the funeral definition by the funeral Certification;	4 Homicide determined building, etc. (Specify)	City or Town, State)
Division of Division of To the Hospital or Attending Ph within 24 hours attended. To the Funeral Director: After th completely filled in by the funeral Medical Certification; 7		at the time, date and place, and due to the cause(s) and manner as stated. In my opinion, death occurred at the time, date and place, and due to the cause(s)
o the vithin 2 o the omplet	one) and manner stated. 29b. Signature and title of certifier 29c	c. License number 29d. Date signed (Month, Day, Year)
F 5 F 0	RALMIN, MO	00060088 09/09/05
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
State	Rachelle Smith, 1745 Eastern Blvd. Balt 31. Date filed (Month, Day, Year) 32. Rugistrar's Signature	mre, MO 21721
Registrar	SEP 1 6 2005 32. Registrar's Signature	,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#8 17 perFH C847 9/16/05 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registra Certificate of Death Reg. No 2005 1. Decedent's Name (First, Middle, Last) 2. Date of Death 13, **Physician** Doris Williams 2005 0640 Sept. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery Suburan Hospital Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ▼ F Months 246-50-8157 69 Director June 11. 1936N.Caroili Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygelen.

Instit (18m 27 is marked other than 'natural', or items 23a or 28a-1 show mit: If tam 27 is marked other than 'natural', or items 23a or 28a-1 show mit: I tam Yadical Examination and the modified at Baltimore N/A Maryland Director ¥TYYes 2 □ No 10f. Zip Code 21215 10e, Street and Number 10g. Citizen of What Country? 5275 Reisterstown Road USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: Black þ 1 ☐ Yes 2 🛣 No Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Owner Self-Employed Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Naomi Gallops Josp. Joseph R. Williams 19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Druid Ridge Cemetery 9/19/05 20c. Location - City or Town, State **X**☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: if any injury or once. Pikesville, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityChatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md21215 21. Signature of Faneral Service Licer see 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heaft failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Pneumonia week /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit and Due to (or as a consequence of) ed by the attending physicien detached for use as the buria Physician/Medical IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 🏖 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peed : Acute renal failure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has Anemia autopsy performed? 1 Yes 2√2 No Metastatic uterine cancer
25. Was case referred to medical 26. Place of Death | Check only one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2√2 No 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 ⊠Natural 2 ☐ Accident To the Hospital or Attending within 24 hours atter death.
To the Funeral Director: Afr 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide (x) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier one) 29b. Signature and little 29c. License number 29d. Date signed (Month, Day, Year) Sept. 14, 2005 D0660117 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, Md 20850 Eric J. Park, MD 9901 Medical Center Drive 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar SEP 1 6 2005

WILLIAMS DORUGIS

State of Maryland / Department of Health and Mental Hygieney 30191 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2:48 A Warren 2006 Momas /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Moshiza 2,5120 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) unk 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1**∑**M 2□F Hours Min Director 10, 1930 215-26-2615 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Modical Examiner must be notified at MD 1 ☐ Yes 2 ☐ No Director Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 5412 Old Court Road by Funerai 21133 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give △ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or item any injury or other traumatic event, the Mudical Exercited 2002. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: black Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk laborer construction unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unk ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk Barbara Gross/niece by marriage 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State ·4 □Donation 5 NOther (Specify) in state Bonald S W 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 Director 655 W. Baltimore Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) septic Shoulo Provsician /Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Examiner Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed ettending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has page 2 инт**ео**? 2**/Х**№ 1 ☐ Yes To the Hospitel or Attending Physicien: director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Annatient 2 EN/Outpatient 3 DOA 1 Yes 2 No this 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 132 Registrar's Signature 1:48 31. Date filed (Month, Day, Year) State Registrar SEP 1 6 2005

			For State Registrar	State of M	aryland /		artment e rtificate			Mental Hy	ygiene Reg. No	71111	5	30192
	Physici /Medic		Decedent's Name (First, Middle, Last	WILLIAM	A. W	OODC	OCK			2. Date of D Month 09-	eath 12-2	005	ar	3. Time of Death 10:00 PM
)	Examir	er	4a. Facility Name (If not institution, give BLAKEHURST					TOM	ocation of Dea ISON					MORE
	Funeral Director		5. Social Security Number 114-07-7986 X	7. Ag	ge (In yrs. last b	Yrs.	If Under 1 Months C		Hours Min		irth la <i>y, Year)</i> 3–191	1 P	Birthpla Country ENN:	ce (State or Foreign SYLVANIA
	e Maryland a-f ehow	ctor	MD. BALTIM	ORE	10c. City, To	wn or Lo		OWSO)N				100	d. Inside City Limits
	1th with th	Funeral Director	10e. Street and Number 1055 WEST JOPP	A ROAD			10f. Zip Co		204		10g. Ci	U. S		•
900	72 hours after death with the Maryland naturel', or Items 23a or 28a-f ehow disal Evantiner must be capified at	þ	11. Marital Status 1 □ Never Married ※ M Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes XXI If Yes, Give Year or Dates:)	1	Vas Deceden f Yes, specify I□Yes 2X	Cuban,	anic Origin? (S Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	0-	14. Race - A Black, W Specify:	hite, et	
Maryland 21215-0036	within ene.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or : 4 YEARS		(Give life. L	OO NOT use i	don <i>e dur</i> retired)	on ing most of wa DENT	rking		ION C	ss/indu	
yland	ould be filed Mental Hygi arked other atic event, I	To Be (17. Father's Name (First, Middle, Last)	OHN R. N	MOODCOCI				MAE		OMPS	ON		
d)	is 1 and 2 should of Health and Mer Item 27 le marke other traumatic	100	JOHN A. WOODCOC 20a. Method of Disposition		29	921		BOU		BLOOMIN	GTON	, INDI	ANA,	47401
Baltimore,	t. Pege rtment o rtant: If njury or		1 ☐ Burial XXCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)		TOP	SERVIC	r place) E CO		Date 14-2005		OWSON,	AMF	RYLAND
Ba	Depermine Depermine Properties of the Properties		21. Signature of Funeral Service Company of the Misease, or company of the	(R.0	G.RUTH)	RU		SON	FUNERAL	. HOME,I		1050 TOWSOI	N,MD	.21204
	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)		ne.	EU				or respiratory a		5	In	pproximate Iterval Between Inset and Death
	cate be executed XX physicien and III is the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Tobal Due to (or as	a consequence	US of):	E						7	Oyrs
	= ~ "	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pregn Other (specif					23d. Date of d Month	elivery Da	ay Year
rds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions co	ntributing to death b	ut not resulting	in the un	derlying caus	e given i	n Part I.	23e. Did t	~			cause of death?
al Records,	is certificete has be director, page 2 sho	e Completed	25. Was case referred to medical							24a. Was auto perfo		24b. Were a prior to death?	autopsy compl es 2	r findings available letion of cause of
Division of Vital	e or Attending Physicis after death. I Director: After this cert d in by the funeral direct	To B	examiner?	1 ☐ Inpatie 28a. Date of Injur (Month, Day) 28e. Place of Injur	y Year) 28b.	Time of Injury	28c.	Other: Injury at Work? 1 Yes		th (Check only of the location ()	dence 6	occurred d Number or I		oute Number
	To the hospiter or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral to the funeral completely filled in by the funeral completely filled in by the funeral completely filled in by the funeral completely filled in the funeral completely fill		29a. Certifier 12 Certifying Phy	sician: To the best of and manner sta	of my knowledge	e, death	occurred at the	ne time, o	date and place	City or To	wn, State)			
)	within 2 To the	Medical	29b. Signature and title of certifier	and manner sta	O			cense nu			29d. Date	e signed (Mor	nth, Day	
	12		30. Name and address of person who co	ompleted cause of de EH ART 1	eath (Item 23a)	(Туре, В	rint) N (HA	UCS S1	BALT				21212
	Stat Registra	e	31. Date filed (Month, Day, Year) SFP 1 6	- 45	ar's Signature	f. 6	berte)					·	

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Amend Item#7, perDVR, G847, 9/17/05 TT

Amond Item 5 State of Maryland 1 Penartingent of Health and Mental Hygiene

		a Amend Ite istrar ent's Name (First, Mid		in G84	47-9-21-C	ertificate of	Death	2. Date of Dea	103.1101	
Physician	n'	orelle A.		-h				Month	A Day	Year 2005 11:45
/Medica	4 5 33	y Name (If not instituti				4b Ciby Town	or Location of Dea	Keg yenny	4c. County o	
Examine	R	oland:Park	Place=E	Retirem		Baltimo	re		n/a	i Death
Funeral Director	218 216	Security Number = 48-9362 12-3610 sidence of Decedent	6. Sex		(In yrs. last birthda Yrs	Months Davs			Y917	9. Birthplace (State or Fo Virginia
show	10a. State		ty		10c. City, Town or	Location				10d. Inside City L
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23e or 3	830	et and Number West 40th	Street			10f. Zip Code 21 21 1	-2134		10g. Citizen of Wr USA	nat Country?
eai', o		al Status ever Married 2□ Ma Vidowed 4□ Divorce	Arried 1 🖂	s Decedent Ev ed Forces? Yes 2∑ No as, Give r or Dates:	ver in U.S. 1	3. Was Decedent of If Yes, specify Cub		Specify Yes or No- to Rican, etc.)		- American Indian, White, etc. White
9 1 2	Siemer Siemer	(Specify only high			(Gi	pedent's Usual Occu ve kind of work done . DO NOT use retire	pation during most of we	prking	16b. Kind of Busi	iness/Industry
Hygiene. Hygiene. other than ", ent, the Mar	Elemen	ntary/Secondary (0-12)	Colle	ege (1-4or 5+) 4)	emaker				n Home
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h and 7 is m		rmant's Name/Relation y Clare Mc		t)	19b. Ma 101	iling Address <i>(Street</i> 3 St. Geo	rge Rd.	ural Route Number Baltimore	City or Town, St.	tate, Zip Code) L210
nent of Healt int: If item 2 iry or other	1 🖒	nod of Disposition Burial 2 Cremation Donation 5 Other (from State	cemetery, c	position (Name of rematory or other pla Cemetery	9-1	7 05	20c. Location - Ci Westernp	
Department of the important: If ite any injury or of Once.	21. Signa	ure of Funeral Service	e Licensee	_		22. Name and Addre		Ruck Tows	on Funer	al Home, In
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hysician	disease of	e Cause (Final or condition in death)	_ a E.	hal-5	Lage u	evaculo	ir den	entia		Onset and Deat
Medical xaminer			Du	ue to (or as a	consequence of):					
	Sequentia if any, lea cause.	ally list conditions, iding to immediate nter Underlying isease or injury	b	ue to (or as a	consequence of):					
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ling physici e as the bu		.E:								
wen signed by the attend hould be detached for us		decedent pregnant e past 12 months? Yes 2 \(\sum \) No Unknown	1 L 4 L	s, outcome of Live birth 2 Pregnant at tir Unknown	☐ Fetal death 3	□Ectopic pregnanc □ Other (s <i>pecify)</i> _	у		23d. Date of Month	
igned b	Part II. Oti	her significant condit	ions contributing	to death but	not resulting in the	underlying cause giv	en in Part I.			fite to the cause of death
been si								1 _ Ye	s 2 1 No 3	□ Probably 4 □Unkn
ate has page 2	5							24a. Was a autops perforn 1 🗆 Yes 2	y prio	re autopsy findings avail ir to completion of cause th? Yes 2
this certificate ral director, pag	a exami		Hospital:			ont 3CI DOA Oth		th (Check only one		
h. After this c funeral dire	27. Mann	Death	28a. [1 □ Inpatient Date of Injury (Month, Day Y		of 28c. Injur	y at	lome 5 ☐ Reside 28d. Describe ho		(Specify)
within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	2	uicide 6 ☐ Could	not be 28e. F	Place of Injury building, etc. (At home, farm, s (Specify)	treet, factory, office	.55 2	28f. Location (Str City or Town	reet and Number of State)	or Rural Route Number,
thin 24 hours the Funeral impletely filled Medical C		Z WIGHT	EXAMINET: ON	o the best of r	camination and/or	ith occurred at the tir nvestigation, in my o	me, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manne	er as stated. I due to the cause(s)
within 2 To the 7 complete	29b. Signa	ature and title of certific		A state		29c. Licens	e number	29	d. Date signed (A	fonth, Day, Year)
	17	nounel	a V/ac	-the	gh m)	D136	57	×	eptende	415, 2005
10	30. Name	and address of persor	who completed	cause of deat	th (Item 23a) (Type 700 W · 4	Print)	ET, BA	LTOTORE	, 07) 2	15,2005
State Registrar		iled (Month, Day, Year CFD 1	6 2005	32. Registrar's	Signature	hood .				

	For State of Many Registrar		artment of Health and tificate of Death	Reg	CUUS	30194
Physician	1. Decedent's Name (First, Middle, Last) Fred Thomas AVEY,	JR.		2. Date of Death Month Sontombo	Day Year	3. Time of Death 12:45 A M
/Medical Examiner	4a. Facility Name (If not institution, give street and number) Reeders Memorial Home		4b. City, Town, or Location of De Boonsboro		4c. County of Death Washingt	1
Funeral Director	216-22-9460 ¹₺M 2□F	n yrs. last birthday) 77 Yrs.	If Under 1 Year If Under 24 H Months Days Hours M		9. Birth 1928 Mar	place (State or Foreign intry) Yland
Maryland -f show lied at	Usual Residence of Decedent 10a. State 10b. County Maryland Washington	City, Town or Lo				10d. Inside City Limits
iter death with the Maryland retems 23a or 28e-1 show ther must be rediffed at Funeral Director	10e. Street and Number 1424 West Church Street		10f. Zip Code 21740	10g	. Citizen of What Co.	untry?
urs after al', or Ita Examina by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Eve Armed Forces? 1 Never Married 2 Married 14 Yes, Give Year or Dates:	r in U.S. 13. 146– 1947	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 ☑ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White Specify: W	
c : 31 =	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during most of v DO NOT use retired) k driver	vorking	b. Kind of Business/I	1
tal H d otl	17. Father's Name (First, Middle, Last) Fred Thomas Avey			lame (First, Middle, Ma Carrie Mira		st
nd 2	19a. Informant's Name/Relationship (Type, Print) Elsie A. Avey — wife	19b. Mailii 1424	ng Address (Street and Number or West Church Str	Rural Route Number, C eet, Hagers	City or Town, State, Z.	ip Code) yland 2174
Pages 1 a ment of Hea ant: If itam ury or otha	20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, crea Cedar La	mataniae athor place)	ept. 7, 2005 H	_	, Maryland
permit. Pages Department of Important: If it any injury or o	21. Signature of Funeral Service Licensee		2. Name and Address of Facility 15 East Wilson B		Funeral Horstown, Ma	
Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a c	onsequence of):	er the mode of dying, such as card	iac or respiratory arrest		Approximate Interval Between Onset and Death
be executed ician and burial-transit	Gaquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events casulting in death) Last Due to (or as a c		rellien			2-3 04
ate be hysicia the bur	a. Advor	ied D	Corlida			for Yeary
ndin Ise a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deliments	very Day Year
igne igne be d	Part II. Other significant conditions contributing to death but r	ot resulting in the u	nderlying cause given in Part I.		cco use contribute to 2 ☐ No 3 ☐ Pro	· ·
The page				24a. Was an autopsy performe	d? prior to c death?	copsy findings availab completion of cause of 2 \square No
thysician this certifical director.	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 27. Manner of Death 1. Natural 5 Pending (Month, Day Y.	2 ER/Outpatie	nt 3□ DOA Other: 4 Nursing	Death (Check only one) Home 5 Residence 28d. Describe how		ify)
Ital or Attanding F rs after death, al Director: After t led in by the funera Certification;	1 ★ Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide (Month, Day Y	- At ho <i>me</i> , farm, st	M 1 Tes 2 No	28f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
Hosp 4 hour Funar fely fill	29a. Certifier (Check only one) 29 Medical Examiner: On the basis of examiners and manner states	amination and/or in	h occurred at the time, date and pla vestigation, in my opinion, death or	ice, and due to the caus courred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To the within 2 To the complet	29b. Signature and title of certifier Hillett M1)		29c. License number D 4656	Since Since	Date signed (Month	*
1-10+1	Dr. Qadir 20311 Lappans 31. Date filed (Month, Day, Year) SEP 0 6 2005	Road Boo		13 301-43	2-8470	

ORIGINAL

State of Maryland / Department of Health and Mental Hygier 105 30195 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** AUGUST 27 2005 MAE LOUISE ADLINGTON 7:05 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** WASHINGTON ADVENTIST HOSPITAL MONTGOMERY TAKOMA PARK | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month Day, Year) | AUGUST 10, 1925 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F 80 Yrs. 208-18-4307 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits show 7 is markad othar than "natural", or tems 23a or 28a-f shov traumatic avant, Tra Medical Examinat must be modified at 1 ☐ Yes 2 X No Director PRINCE GEORGES LANHAM the 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Heatth and Mental Hygiene. Int: If item 27 is markad othar than "natural", or ttems 23a or? 5415 WHITFIELD CHAPEL ROAD 20706 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOSEPH WALKER ELEANOR SNYDER 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If itam 27 is any injury or othar trau once. FRANCIS R. ADLINGTON/ HUSBAND 5415 WHITFIELD CHAPEL RD LANHAM, MD 20706 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other plan
MARYLAND VETERANS
CEMETERY 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/1/2005 CHELTENHAM, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ROBERT E. EVANS FUNERAL HOME 21. Signature of Fuperal Service L 16000 ANNAPOLIS ROAD BOWIE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Heart Block Complete **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Londuction Examiner Unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine and I-transit Hypertension Unknown The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) the red 9 Unknown 9 Unknown signed by the Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Erythematosus Lupur 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▼No autopsy performed? certificate 1 Yes or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 After thi 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: A 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide hours after within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To tha Funcompletely 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MARYLAND /Cobs ant Ang 28, 2005 22846 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAKOMA PARK, MB 20912 7901 MAPLE AVE DIBIANCO MD KUBERT 31. Date filed (Month, Pay Year) 0 2005 32. Regerrar's Signature State Registrar

Amend Items 23a,25 per ME, C850 12/14/03dhb
Reg. No. For State Registra 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** AUGUST ALEXANDER ADRIANNE 2005 6:05 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1961 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 X F Yrs. Director 213-86-3756 43 MARYLAND December 30 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h County or 28e-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Heatith and Mental Hygiene. sent of Heatith and Mental Hygiene, sent: If item 27 is marked other then "naturel", or Hems 23a or 28e-1 show ury or other treumetic event. It is Medical Examination to nothing a 1X Yes 2 □ No Director PRINCE GEORGE'S MITCHELLVILLE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1604 TERRAPIN HILL DRIVE 20721 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CONTROL SPECIALIST GOVERNMENT 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MILDRED DENNIS NICK JAMES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20721 19a. Informant's Name/Relationship (Type, Print) 1604 TERRAPIN HILLS DRIVE MITCHELLVILLE, MARYLAND KEVIN ALEXANDER/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Importent: If eny injury or once. 9/1/2005 LANDOVER, MARYLAND 1 4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Sepsis Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner CERTIFICATION APPROVED B THE TICAL EXAMINER physicien and s the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. 1 Yes 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an Multiple Sclerosis autopsy 1 Yes 2 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ¥ Yes 2 No 10 Inpatient 2 ER/Outpatient 3 DOA 븅 28a. Date of Injury (Month, Day Year) After thi 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide within 24 hours a To the Funerel D Filled the Hospital 29a. Certifier 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0060362 6 Type Print) Serry way, Boilie 30. Name and address of person who comparted cause of death (Item 23a) (Type, Print) 7202 46666 5 + mill 31. Date filed (Month, Day, Year) AUG 3 1 2005 . Registrar's Signature State Registrar

			1 - For State Registrar	State of I	Marylar	nd / Depa		t of H	ealth a			-	005	3019	97
	Physici	an	1. Decedent's Name (First, Middle,	Last)		-	120				2. Date of Dea Month	Day	Year	3. Time of D	
	/Medic	al	4a. Facility Name (If not institution,	give street and numb	er)		, —		Location o	-	August	_	2005 County of Dea	3:00 A	A M
1	Examin	er	Montgomery Gene				vo. Oxy,	01n		Joan				omerv	
	Funeral		5. Social Security Number		Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under	24 Hrs. 8	B. Date of Birth (Month, Day	Year)		thplace (State or ountry)	Foreign
	Director		N/A Usual Residence of Decedent	1 L I W 2 L Y	8	30 Yrs.	ll				March 2				
	yland now		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City	Limits
	Ba-f st	ctor	Maryland Monts	omery		01ney		·						1 Tes	2 ₩ No
	72 hours after death with the Maryland natural; or Items 23a or 28a-f show diest Examiner must be nutified at	Completed by Funeral Director	10e. Street and Number				10f. Zip				1	0g. Citiz	en of What C	ountry?	
	eath v	erai	18003 O'Hara Co	12. Was Decede	ent Ever in U	J.S. 13.	Was Deced		832	nin? (Spec	ify Yes or No-		banon 4. Race - Am	erican Indian	
(0	or Item	Fun	1 Never Married 2 Marrie	Armed Force	es?			ify Cuba		, Puerto R	ify Yes or No- ican, etc.)		Black, Whi		
21215-0036	ours a	d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Date	es:		1□ Yes 2	2000	Specify:					ite	
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12	withir iene. than	omp	Elementary/Secondary (0-12)	College (1-4	or 5+)		choo		teac	her		F	<i>duca</i>	tion	
d 2	e filled other vent,	Be C	17. Father's Name (First, Middle, L	ast)				Ţ	18. Mothe	r's Name (First, Middle, i	Maiden S	Sumame)		
ylar	Menta Menta arkad	To	Wadee Azar							nafika					
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, Ite Madical Examination and be nutified at any injury or other traumatic event, Ite Madical Examination and be nutified at any or other traumatics.	1	19a. Informant's Name/Relationsh					,			Route Number	. ,	07 087590	Zip Code)	
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Baltimore,	ages ant of tr: If it		1 ☐Burial 2 ☐ Cremation 4 ☐ Donation 5 🕅 Other (Sp		110	cemetery, crei :e of H	eaven						850		
altir	mit. F partme sortar / injur		21. Signature of Furieral Service L		-11.6	22	Ceme Name an	tery d Addres	s of Facilit	ug. 3	1.2005 uneral	SIL	er Spr	ing,MD	
Ö	Per E S		Muhard I	Lales		50	ancis O Uni	vers	ity E	lus Fi	merai WSil	nome ver	Spring	MD 2090	01
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	omplications that cau nly one cause on eac	sed the dea h line.	th. Do not ent	er the mode	e of dying	g, such as	cardiac or	respiratory arr	est,		Approximate Interval Betw Onset and De	een
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	nd nd transit	Examiner	that initiated events	c. Gangi							-				
760,	ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or	as a consec	quence of):									
687	icate t	dical		d											
Box 6	death certifical e attending phy d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco								, 2	3d. Date of de	livery	
	0 0 9	sicia	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknow	it at time of d		□Ectopic pro □ Other (sp						Month	Day Ye	ear .
P.0	that the de ed by the detached	Phys	9 🗆 Unknown		91						OO- Dida-				
	es De d	þ	Part II. Other significant condition	is contributing to deat	in but not res	suiting in the u	nderlying ca	ause give	en in Paπ I.		_	bacco us es 2□		o the cause of de robably 4 □Ur	
orc	> 0 70	etec									24a. Was a	-		utopsy findings av	
Division of Vital Records,	has has	Completed							-		autops	ned?	prior to death?	completion of car	use of
ta	ician: Th certificate rector, pag	ø	25. Was case referred to medical						26. Place	of Death	1 Yes	2 No	1 🗌 Yes	3 2 □ No	
Į.	G S G	To B	examiner?	Hospital: 1	atient 2	ER/Outpatier	nt 3□ DO	A Othe	ar		e 5 ☐ Reside		Other (Spe	ecify)	
0 0	fter fter		27. Manner of Death Natural 5 Pending		Injury Day Year)	28b. Time o Injury		8c. Injury Work	at c?	-	ld. Describe ho	ow injury	occurred		
isio	Attending it death. ector: After by the fune	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could n	ot be	Lloiuny - At h	nome, farm, str	M factors	1 🗆 \	Yes 2		of Location (St	reet and	Number or E	ural Route Numb	
Div	after Direct	Certification:	4 Homicide determin	building	, etc. (Speci	ify)	eet, ractory	, onice	-		City or Town	n, State)	744111267 () 71	ulai i loute i vallo	or,
	ospita hours uneral ly filled		29a. Certifier Certifying	Physician: To the be	est of my kn	owledge, deat	h occurred	at the tim	ne, date an	d place, ar	d due to the c	ause(s)	and manner a	s stated.	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	fedical	one)	xaminer: On the basi and manna	r/stated.		-								
	To To 1	Σ	29b. Signature and title of cortifier	C-+	5	1 —	290	License	number	9 17	7 2	9d. Date	signed (Mon	th, Day, Year)	_
	1		20 Nome and the	1		7.00-1.0	Delativ	P	6/0	/_	11 7/1A	0.	40	- 200	5
			30. Name and address of person whihee O Kw 31. Date filed (Month, Day, Year) AUG 3 1	run, M.D.	20500	Sere	a Me	ada	ws P.	rkni	K G	e Mi	on towar	MD	16
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	Regist	ar	AUG 3 1	ZUU3	NO S	S. James	A Second								

			1 - For State Registrar	State of Man		rtment of H			2005	30198
			Decedent's Name (First, Middle, Las	it)				2. Date of Death Month		3. Time of Death
	Physicia		Daisy	Mae	Aldrida	ge		SEPTEMBE		5 11:15 A ^M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	ath
			MEMORIAL HOSPITAL			CUMBERI			ALLEGAN	Υ
	Funeral		5. Social Security Number 6. Se		In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	'ear) 9. Bi	rthplace (State or Foreign country)
	Director		213-28-4156	X . /	79 Yrs.			02/28/192	6 Wes	t Virginia
	and	}	10a. State 10b. County	1	Oc. City, Town or Lo	cation				10d. Inside City Limits
	Mary	jo	MD Allegany		Cumber	rland				1 ☐ Yes 2 ☐ No
	the 28a	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What C	ountry?
	3a or	0	10210 Cottag	ge Inn Lane, N	1.E.		21502		USA	
	death	Funerai	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Spanic	ecify Yes or No-	14. Race - Am	
ဖွ	or its	F.	1 Never Married 2 Married	1 ☐ Yes 2√ No		Yes 2 No	Specify:	rindari, dio.)	Black, Whi	ite, etc.
21215-0036	ural',	d by	3 X Widowed 4 □ Divorced	Year or Dates:						White
<u>7</u>	"nati	Completed	15. Decedent's Ed (Specify onfy highest gra		(Give	lent's Usual Occupa kind of work done d DO NOT use retired,	luring most of work	ing 16	6b. Kind of Business	s/Industry
72	withir sne. than	du	Elementary/Secondary (0-12)	College (1-4or 5+)			/			
р Б	Hygie ther int,		9 17. Father's Name (First, Middle, Last)	Made Francisco		lomemaker	18. Mother's Name	(First, Middle, Ma	Homemaker niden Sumame)	
Maryland	d be ental ced o	To Be	Verly	Clav	Westfall		Grace	Sarah	Shook	
Z Z	shoul nd Me marl	-	19a. Informant's Name/Relationship (7			g Address (Street a			City or Town, State,	
Š	nd 2 alth a 27 is		Bonita Wagus / nied	ce	P.O. Bo	ox 308, Pin	ev Point. N	larvland 2	0674	
altimore,	perrait. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Itam 27 is marked other than "natural; or itams 23e or 28e-f ehow any njury or other traumatic event, the Medical Examinar must be notified at ance.		20a. Method of Disposition	1	20b. Place of Dispos				c. Location - City o	r Town, State
Ë	Page nent c int: If		1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		Hillcrest M			2005 Cı	mberland, N	Mary land
ati	pernit. Departm Imports any inju		21. Signature of June 1 Service Licen						Tuneral Home	
B	20 E 2 8		Libert C-	alams					Maryland 2	
ı			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the one cause on each line.	ne death. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between
뺼	Pnysician		Immediate Cause (Final disease or condition	. Multi	focal Atrial	Tachycardi	ia			Onset and Death Few hours
	/Medical		resulting in death)		consequence of):	Littly Cultur	.u			2011 110 0110
	Examiner		Sequentially list conditions,		ic Obstructi	ve Fulmenai	ry Discase			Tears
	be is	Examiner	Sequentially list conditions, if any, leading to infracial cause. Enter Underlying Cause (Disease or injury	Due to (ur as a c	ounsaquance/ot):					
	and I-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a c	consequence of):					
8760,	cate be executed physician and the burial-transit	ä								
687	ficate p physics the	edicai		, d.					,	
Box	requires that the death certifi been signed by the attending f hould be detached for use as	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		1=			23d. Date of de	alivery
m	death e atte d for	Physician/M	in the past 12 months? 1 ☐ Yes 2 🖾 No	1□Live birth 2 [4□Pregnant at tin		Ectopic pregnancy Other (specify)			Month	Day Year
Ö.	t the by th lache	hys	9 Unknown	9□ Unknown						
o,	res tha igned be de	by P	Part II. Other significant conditions of	-	_	,	on in Part I.			to the cause of death?
ord	v require been si should l	ted	Rheumatoid Arthri	tis, Abdominal	l Aortic Ane	urysm		1 ☐ Yes	2 X No 3 □ F	robably 4 Unknown
Records,	aw Is b	ple						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
H	The ate h page	Completed						performe 1 ☐ Yes 2		s 2 No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hannital.		04	The state of the s	(Check only one)		
of	tending Physician: leath. tor: Atter this certific the funeral director.	2	1 Yes 2 No		2 ER/Outpatien		4 🗆 Nulsing no		ce 6 Other (Spe	ecify)
On C		ion	27. Manner of Death 1.XXNatural 5 □ Pending	28a. Date of Injury (Month, Day Y		28c. Injury Work		28d. Describe how	injury occurred	
isi	l or Attending after death. Director: Afte I in by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	9	y - At home, farm, str		-	28f. Location (Stre	et and Number or F	Tural Route Number.
Division	after Direction by	Certification:	4 Homicide determined	building, etc. ((Specify)	, asis, y since		City or Town,		
	e Hospital or 24 hours afte e Funaral Dir etely filled in		29a. Certifier 1X Certifying Ph	ysician: To the best of r	my knowledge, death	occurred at the tim	ne, date and place,	and due to the cau	se(s) and manner a	s stated.
	To the Hospital or At within 24 hours after of To the Funaral Direct completely filled in by	edical	(Check only 2 Medical Examone)	niner: On the basis of ex and manner state	xamination and/or inved.	estigation, in my or	pinion, death occurr	ed at the time, date	e and place, and du	e to the cause(s)
	To the h within 24 To the f complete	ž	29b. Signature and title of pertifier			29c. License	number	290	f. Date signed (Mon	th, Day, Year)
	2		Huna Stair	M_{ij}		D4634	46	5	September 6	, 2005
ζ.	713		30. Name and address of person who	completed cause of dea						
-			Huma Shakil, M.	D., 625 Kent	Avenue, Cun	mberland, M	aryland 21	502		
	Sta Registi		31. Date filed (Month Day, Xear) SEP 06 20	05 32. Ogistrar's	s Signatury	parle				

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			1 - State Amend Item	State of M L&Unpend Ite	aryland m 23 a-	/ Depa	artment of	Health	and Mental I G849 11-2	lygier 9-05	2005	30199
	Dharaia		Decedent's Name (First, Middle				imoate o	Dean	2. Date of	Death		3. Time of Death
	Physic /Medi	cal	William Ear 4a. Facility Name (If not institution)				41. O't. T				Pay 10, 20	
	Examir	ner	CUMBERLAND STR	EET				SPRIN	IG			GTON CO
2	Funeral Director		5. Social Security Number 219–44–4930	6. Sex 7. Ag	je (In yrs. las 58	Yrs.	If Under 1 Year Months Day		Min. 8. Date of (Month)	/1946	9. E	Sirthplace (State or Foreign Country)
9	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	e Mary 3a-f sh	ctor	MD Washi	ngton	Cle	ar Sp	oring					1 ☐ Yes 2 🛣 No
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hyglene. Important: if item 27 ie marked other than "natural", or iteme 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	Funeral Director	10e. Street and Number 11823 One Bank	Road			10f. Zip Code 2172				Citizen of What	Country?
	teme 2	uner	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent of f Yes, specify Cu	Hispanic O ban, Mexica	rigin? (Specify Yes or in, Puerto Rican, etc.)	No-	14. Race - Ar Black, W	merican Indian,
21215-0036	rai', or i	ρ	1X Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 Tyes 2 15 If Yes, Give Year or Dates:	No		1⊡Yes 2 X ΩN	o Specify	;;		Specify: W	hite
15-0	n 72 h	Completed	15. Decedent (Specify only highes	t grade completed)		16a. Deced (Give	dent's Usual Occ kind of work dor DO NOT use reti	upation e during mo	st of working	16b.	Kind of Busines	ss/Industry
	filed withi Hygiene. other than	Comp	Elementary/Secondary (0-12)	College (1-4or !	5+)		curity 0				Pris	son
and	otal Hy ed oth	Be	17. Father's Name (First, Middle, I William Earl Ba	·					ner's Name (First, Mid ne Marie B		-	
Maryland	should and Men marke	2	19a. Informant's Name/Relationsh					et and Numb	per or Rural Route Nu	mber, City	or Town, State	
	1 and 2 Health em 27 i		June M. Baughma 20a. Method of Disposition	n / Sister	20b Plac				eet, Hager	-	Location - City	
mor	Pages sent of int: If it		1 Notified of Disposition 1 Notified of Disposition 1 Cremation 4 □ Donation 5 □ Other (Sp				sition (Name of natory or other p VN Mem F		09/15/2005		agerstov	
Baltimore,	permit. Depertri Importa any inju		21. Signature of Funeral Service L	icensee		22	. Name and Add	ress of Facil	ity Gerald	N. Mi	innich H	Tuneral Home
			23a. Part1. Enter the disease, or	complications that caused	the death.	Do not ent	05 N. Po er the mode of d	tomac ying, such as	Street, H s cardiac or respirator	agers	stown, N	Approximate
	Physician		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a Saddle F		ary E	mbolus					Interval Between Onset and Death
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	sit ad	lner	Sequentially list conditions, if any, leading to in internate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a corisaquar	nga of).						
Ć,	death certificate be executed e attending physician and nd for use as the burial-transit	Examine	that initiated events resulting in death) Last	c. Leg init		nce of):						
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ox 6	leath certific attending p	/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnance	y					23d. Date of d	Alivany
P.O. Bo		Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnar Other (specify)	су		-	Month	Day Year
	law requires thet the as been signed by th 2 should be detache	by Ph	Part II. Other significant condition	ns contributing to death b	ut not resultin	ng in the ur	nderlying cause o	oven in Part	I. 23e. D	id tobacco	use contribute	to the cause of death?
Records,	w requir been si should I										2⊠No 3□I	Probably 4 Unknown
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Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	(10 William)		10		e of Death Check on	ly one)	•	COMM
ō		on; To	1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju	ent 2 ER	VOutpatien Bb. Time of Injury		ury at ork?	ursing Home 5 ☐ R 28d. Descrit	esidence be how inj		ecity) SCENE ubjectoigjure
Division	deatl deatl ctor: / the	catlc	2 X Accident investig 3 ☐ Suicide 6 ☐ Could n	8-30-05 ot be			M 1[□Yes 21X	Paintu accide	il to	walk fo	bjectoiniure ollowing
-	7 8 7 5	Certification;	4 Homicide determi	road	c. (Specify)	e, iaiii, siit	эөт, тасхогу, отто	,	City or Mile M	Town, Sta	r 8,Was	Sural Route Number de Southbounde hington Co., M
	To the Hospital of within 24 hours of To the Funaral D completely filled in	Medical	29a. Certifier 1 ☐ Certifying (Check only one)	Physician: To the best xarriner. On the basis of and manner st	examination	dge, death and/or inv	occurred at the restigation, in my	time, date ar opinion, dea	nd place, and due to t	he cause/	s) and manner :	ac etatod
	To th Withir To th comp	Me	29b. Signature and title of certifier	12/12	//x		29c. Licer	nse number			ate signed (Mor	
			20 Name and address of	NA C	noth (last co	201/7		СМЕ		SEP	TEMBER :	12, 2005
SH-		li	30. Name and address of person v	Completed cause of d	eath (Item 23		$111 \; \mathrm{PENI}$	N STRE	ET, BALTIM	ЮRЕ,	MARTLA	ND, 21201

State Registrar 31. Date filed (Month, Day, Year)
SEP 14 2005
32. Jegi

State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. 2005 Certificate of Death 2. Date of Oeath 1. Decedent's Name (First, Middle, Last) Month 09 2005 **Physician** 7:00A PHILIP HUFFINGTON BANKS, SR. /Medical 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner WICOMICO **SALISBURY** 206 EVERGLADES DRIVE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 02-15-1930 9. Birthplace (State or Foreign Country) ALLEN, MARYLANI 7. Age (In yrs. last birthday) 5. Sociel Security Number **Funeral** 1 □ M 2 □ F 220-26-8416 75 Yrs. MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show other traumatic event, the Madical Examinar noust be notified at 1 ☐ Yes 2 ☐ No Director MD WICOMICO SALISBURY 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21804 USA or items 23s 206 EVERGLADES DRIVE Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural, or tiem any injury or other traumatic event, the Mattern Expense. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ENTREPRENEUR SELF EMPLOYED 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be LAURA HUFFINGTON OLIVER O. BANKS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BARBARA LEE BANKS - SPOUSE 206 EVERGLADES DRIVE, SALISBURY, MARYLAND 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) CREMATORY OF DELMARVA 09-02-2005 DELMAR, DELAWARE 21. Signature of Funda Service Licensee 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ISCHEMIC HEART DISEASE YEARS **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 DFetal death 3 DEctopic pregnancy Year jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) detached 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Division of Vital Records, page 2 should be TROSTATE 1 X Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2□ No certificate 1 Yes 2 X No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ☐ Nursing Home 5 N Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ▼No Certification; To 3□ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Injury at Work? 1 XNatural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No s after death. investigation the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide within 24 hours a To the Funeral I filled Fo the Hospital 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifies D3657-6 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who MD 21801 560 RIVERSIDE MD RAULTZ 31. Date filed (Month Day, 32. Agistrar's Signature State Topadi, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 20530201 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Catherine Cecelia BORNE eptember 530 AM 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hagerstown
If Under 1 Year H Under 24 Hrs. 8. Date Washington Washington County Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Hours 1 □ M 2 1 1 F 215-14-2732 Yrs. 89 30, July Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13312 Hunter Hill Drive, Apt. E 21742 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 Ki Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) secretary legal 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sabatino Carpegna Antonia Castellani 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Ann Baker - daughter P. O. Box 247, Maugansville, Maryland 21767-0247 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 9/8/2005 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory Hagerstown, Maryland 21. Signature of Eugeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Renal failure disease or condition resulting in death) Due to (or as a consequence of) Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown

Physician /Medical **Examiner**

permit. Pages 1 and 2 Department of Health al important; if item 27 ie eny injury or other trau

Physician

/Medical

Examiner

Funeral

Director

"netural", or items 23a or 28a-f ehov adical Examiner must be natified at

d other than "

Directo

Funeral

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Completed

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

1 and 2 should be Health and Mental

Examine nding physician and use as the burial-translt signed by the a Completed Be ٩ tor: After thi Certification:

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/Medical δ

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MYOCARDIAL INFARCTION

1 Yes 2 No 24a. Was an

3 Probably 4 Unknown

autopsy performed? res 2 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 Natural

29b. Signature and title of certifier

2 Accident

4 T Homicide

3 Suicide

1 Impatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

2 ER/Outpatient 3 DOA 28b. Time of Injury Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Hospital:

29d. Date signed (Month, Day, Year)

21740

Machour 00062562

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADNAVI HUBBLY HAGERSTOWN MARYLAND

28f. Location (Street and Number or Rural Route Number, City or Town, State)

09-05-05

WASHINGTON

31. Date filed (Months Par Year)

6 ☐ Could not be

COUNTY HUSPITAL 32. Registrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

deeth.

within 24 hours

State of Maryland / Department of Health and Mental Hygiene 2005 30202 1 - For State Registra Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) September Da ^y04, 2005 **Physician** LINFORD 7:50 pm GLENWOOD BEST /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner REEDERS MEMORIAL HOME **BOONSBORO** WASHINGTON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Min. | MARCH 18, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 10XM 2□F Yrs. 219-14-8001 82 MARYLAND Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County item 27 ia marked other then "natural", or items 23e or 28e-1 show other traumatic event, the Medical Examinar must be notified at 1XYes 2 No HAGERSTOWN MARYLAND WASHINGTON Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21740 U.S.A. 219 SOUTH FORK DRIVE by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 11 STATIONARY ENGINEER RAILROAD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARY E. MILLER ERNEST McCLELLAN BEST 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 219 SOUTH FORK DRIVE, HAGERSTOWN, MARYLAND 21740 KATHRYN R. BEST/SPOUSE Importent: If item eny injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State BROWNSVILLE HGTS. CEM! 09/08/2005 BROWNSVILLE. MARYLAND 21. Signature of Juneral Service Licensee 22. Name and Address of Facility FAST FUNERAL HOME 7606 Old National Pike Kelly A. Zimmerman Boonsboro, Maryland 21713 23a. Fart1. Effer the lisease, if a mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock a lailure. List only one cause on each line. Approximate Interval Between Onset and Death Pneymonia Immediate Cause (Final 2 week Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner YOKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has b autopsy throscle certificate 1 ☐ Yes 2 ☐ No 2 No Hospital or Attending Physician: 25. Was case referred to med examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes X No P 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D44996 6, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301-432-8470 Zafar Malik 20311 Lappans Rd. Boonsboro, MD 21713 32. Registrar's Signature 06 2005

DHMH 17 Rev 1/2001

State Registrar

			1 - For Stata Registrar	State o	of Marylan	d / Depa <i>Ce</i> a	artment of H	Health Death	and M	ental Hyg	iene 0 (05	30203
			1. Decedent's Name (First, Middle,	Last)						2. Date of Dea	th		3. Time of Death
	Physicia /Medic		Artie	J. Burg	ess					Month August	30	Year 2005	8:51 A M
	Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, Town, o	or Location	of Death			y of Death	
			Washington	Adventis	t Hospi	tal	Ta	koma				Monte	gomery
	Funeral		5. Social Security Number 6	. Sex 1 □ M 2 🕅 F	7. Age (In yrs. i		If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birth (Month, Day	Year)		place (State or Foreign ntry)
	Director		579-44-8698	1 M 2 Q P	9	2 Yrs.		1.00.0		July 18			ginia
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	y. Town or Lo	cation			800			10d. Inside City Limits
	sho	ក	,										1 TYYes 2 □ No
	the A	Director	Maryland Princ	<u>e George</u>	's	Н	yattsvil 10f. Zip Code	le			D= 0:4:	110	
	with		4922 LaSalle	Do - J			TOI. ZIP CODE	007	0.0	'	0g. Citizen of		
	death with the Maryland ims 23a or 28a-f show	Funeral	11. Marital Status		edent Ever in U.	S 13	Was Decedent of I	207		city Vee or No-			States
_	ter d	Fun	1 ☐ Never Married 2 ☐ Marrie	Armed Fo	orces?	0. 13.	Was Decedent of I f Yes, specify Cub	an, Mexica	n, Puerto f	Rican, etc.)		ack, White,	
3	hours after turel', or Its	by	3 Widowed 4 □ Divorced	If Yes, Gi Year or D	ve		1 ☐ Yes 2 ☐XNo	Specify.	:		Specia	ту: В1	ack
2-003c	be filed within 72 hours after death with the Marylan del Hygiene. del Hygiene.	Completed	15. Decedent's	Education		16a. Dece	dent's Usual Occup	pation			16b. Kind of E	Business/Ir	ndustry
<u> </u>	within 72 ene. then "nel	ple	(Specify only highest Elementary/Secondary (0-12)	College (life.	kind of work done DO NOT use retire	during mos d)	st of workir	ng			
Z	or th	Con	8th	- 3			Beauti	cian			Se1	f-Emp	loyed
/land	be filed value Hygie od other i	Be (17. Father's Name (First, Middle, La	,				18. Moth	er's Name	(First, Middle, I	Maiden Sumai	me)	J
<u>X</u>		2	John W. L	ewis						Lillian			
Mar	and and ls rr		19a. Informant's Name/Relationship				ng Address (Street						
	s 1 and 2 should t Health and Mer item 27 Is marke other treumatic		Carrie M. Broo	mfield/D				ersey					, DC 20001
altimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from		lace of Dispo emetery, cre	sition (Name of natory or other pla	ice)	D	ate	20c. Location	- City or To	own, State
	permit. Page Department of Important: If any Injury or once.		'4 ☐ Conation 5 ☐ Other (Spe	cify)		ncoln	Memorial	Cem,					d, MD
g	ermit bepar mpor ny In		21. Signature of Furieral Service Lie	900		22	. Name and Addre			ewart F			
	70 5 8 Q		John .	Margary	1					., N.E.		, DC	20019
			23a. Part1 Enter the disease, or conshock, on heart failure. List or	omplications that only one cause on e	each line.						est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	KES	PIRA	PURY	+A	IWR	E			Onset and Death
	/Medical Examiner		resulting in dealth)	Due to	(or as a consequ	ience of):	ARY E						
		_	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	,								
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	540 (0	ATH	1191/15	UMUN	1. C.	ARDI	OVASCU	LAK DI	JEST	6
	axecu and al-tra	xar	that initiated events resulting in death) Last	c Due to	(or as a consequ								-
8/PU	cate be executed physician and the burial-transit	dical	(d									
Q	ificat g phy as the	ab ab											
X Q Q	andin use	N/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		42 . U. 700				23d. Da	ate of delive	erv
	death e atte	Icla	in the past 12 months? 1 □ Yes 2 ☑ No	4 ☐ Pregr	ointh 2 □ Fetal nant at time of de		Ectopic pregnance Other (specify) _	у			Me	onth	Day Year
j.	at the death certifice I by the attending pl stached for use as t	Physician/M	9 🗆 Unknown	9□ Unkn	own								
r.	res that igned b	by P	Part II. Other significant condition	s contributing to d	eath but not resu	Iting in the u	ndertying cause giv	ven in Part I	l.	23e. Did tob	acco use con	tribute to t	he cause of death?
Ë	w require been sig should b		PNEUMONIA	, 14	PERLI	ENTI	UIV,			1⊌ Ye	s 2 No	3 ☐ Prob	pably 4 □Unknown
Kecord	The law requires that the death certifi te has been signed by the attending l age 2 should be detached for use aa	Completed	DIABETTE	nolli	M,	KEW.	AL FAI	IUR	G	24a. Was a	n 24b.	Were auto	psy findings available impletion of cause of
	sician: The law certificate has irector, page 2 s	mo;	ARECITY	DA	MANIT	A				autops perform	ned?	death?	
Vital	ian: rtifica stor, j	Bec	25. Was case referred to medical		VICIVI			26. Place	e of Death	(Check only on		103	2010
0 >	Physicii this cer al direct	ToE	examiner?	Hospital:	Inpatient 2	ER/Outpatier	t 3 DOA Oth	ner: 4 🗆 Nu	ursing Hom	ne 5 ☐ Reside	nce 6 Oth	her (Specif	ý)
	ding Ph h. After thi funeral		27. Manner of Death Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of	28c. Injur Wor	ry at	2	8d. Describe ho	w injury occur	rred	
0	oter: A	catle	2 Accident investiga	1				Yes 2	No				
UIVISION	I or Attencater death	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 280. Place	of Injury - At ho ing, etc. (Specify	me, farm, str	eet, factory, office		2	8f. Location (St. City or Town	reet and Numl	ber or Rura	al Route Number,
	urs a										·		
	o the Hospital or Attending Physician: in 24 hours after death or the Fundal or the Completely filled in by the funeral director, ompletely filled in by the funeral director,	edical	29a. Certifier Certifying (Check only 2 Medical E)	aminer: On the b	asis of examinat	wledge, death tion and/or in	occurred at the tirvestigation, in my o	me, date <i>ar</i> opinion, dea	nd place, a ath occurre	nd due to the ca d at the time, da	tuse(s) and mate and place,	anner as s and due to	tated. the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and man	ner stated.		29c Licens	se number		20	ad Date signe	d (Month	Day Voar
	F ₹ F 8		1 CANCIA	whim	dan.		75	376	7	2.	A11611	5 1 2	0 M 200 V
n	(2)		30. Name and address of person wi	o completed ac-	se of death (lts.	239\ /T	Point) Ro	ian 9	/ Sharame	zundar	MD	-10	1
1	- (3)		10810 DAM	Un train	1 Plaz	Coay (Type,	mali 2	12	(10	this	burg	MI	0 M, 2005
	Sta	te	31. Date filed (Month, Day, Year)	1.00	Registrar's Signat	ture	V V V V V	- /			/	-/	
477			CED 4 6 204	SC (2)									

		State of Maryland / Department 1 - State Registrar Certificate		•	2005	30204
Physic	ian	1. Decedent's Name (First, Middle, Last) Blaine Bert Barnhart		2. Date of Death Month 08	30 2005	3. Time of Death 7:10 P M
/Medi Examii			Town, or Location of Death		4c. County of Death	
LXamii	101	Charles County Nursing Center LaP	Plata		Charles	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 163-22-2546 1 № № 2 □ F 78 Yrs. Months	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Yes 06-08-19	9. Birth	place (State or Foreign
Director		Usual Residence of Decedent		00-00-13	727 11120	abethtown ,PA
Maryland	tor	MD 10b. County 10c. City, Town or Location Capitol Height	hts			10d. Inside City Limits 1 ☐ Yes 2 No
ith the or 28a	Oirec	10e. Street and Number 10f. Zip			Citizen of What Cou	ntry?
ath w	rai	0000 1101111111111111111111111111111111	743		SA	
perillinioie, IMarylatina Z.I.Z.I.3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 Is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic evant, Ite Medical Examination of the Indiana ange.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes, Give Year or Dates: 1945–64	lent of Hispanic Origin? (Spe ify Cuban, Mexican, Puerto i 2 X No Specify:	Rican, etc.)	14. Race - Ameri Black, White Specify: Cau	etc.
nin 72 hou in "natura	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usua (Give kind of wor	at Occupation rk done during most of working re retired)	ng	Kind of Business/Ir	
ar tha	Com	12 Electric		11	US Govern	ment
d be file antal Hy sed oth	Be	17. Father's Name (First, Middle, Last) Ira Bote Barnhart		e (First, Middle, Maid e Gainer	len Sumame)	
shoul and Me s mark umati	2		(Street and Number or Rura		y or Town, State, Zi	p Code)
and 2 and 2 ealth a m 27 l			dering Drive	Brandywi	ne, MD 20	613
ages 1 nt of H or oth		20a. Method of Disposition 1	ther place)		Location - City or T	
Definition Department of popular		*4 □ Donation 5 □ Other (Specify) MD Veterans (21. Signature of Funeral Service Asserts M00053 22. Name and	Cemetery 9-8- d Address of Facility		heltenham Box 156	, MD
De			Funeral Home		rf, MD 20	604
Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a.	e of dying, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death
/Medical Examiner	ı	Due to (or as a consequence of):	art Failure	i:		
ii d	iner	if any leading to immediate Due to (or as a consequence of):	Jest Jestion			
be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last				
icate be exphysician s the buria	dicai	d				
On VItal necolds, F.O. DOX 001000, Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown 2 Telephane 3 Ectopic properties 3 Ectopic properties 4 Pregnant at time of death 5 Other (spa			23d. Date of deliv Month	very Day Year
that the ned by detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	ause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
w requires to been signed should be				1 ☐ Yes	2□No 3□Pro	bably 4 Unknown
Physician: The law requires certificate has been all director, page 2 should	ompieted			24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of
VICAN: ician: certifica ector, p	BeC	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
ding Physic After this co	မ	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DO 27. Manner of Death 1 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DO 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury	8c. Injury at Work?	me 5 Aesidence 28d. Describe how in		(y)
To the Hospital or Attanding within 24 hours after death. To the Funaral Director: Atler completely filled in by the funeral	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)	1 Tyes 2 No	28f. Location (Street City or Town, St		al Route Number,
Hospita 24 hours 1 Funaral stely filled	dicai C	29a. Certifier (Check only one) 14 Eertifying Physician: To the best of my knowledge, death occurred to the basis of examination and/or investigation, and manner stated.	at the time, date and place, a in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as s and place, and due t	stated. to the cause(s)
To the within To the comple	Med	29b. Signature and title of certifier 29c	: License number	29d. I	Date signed (Month,	Day, Year)
		· Rechard Thers MD	59158	8	131/05	
00 D = 01 1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Clonused	ID 21720	1 1	
MP 591	ate	Dr. Richard Rees, 15013 Rolling Hills Road 31. Date filed (Month, Day, Year) 32. Resistrar's Signature	, Gleriwood, M	ח 21/38		
Regist		31. Date filed (Month, Day, Year) SEP 0 6 2005 32. Registrar's Signature	,			

State of Maryland / Department of Health and Mental Hygie 70 0 5 30205 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month **Physician** Burgess , Sr. Α. August 28 2005 1:15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 605 Sand Road Severn Anne Arundel 8. Date of Birth (Month, Day, Year) Sept. 8, 1 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1**X** 1 M 2 □ F 78 1926 Director 236-22-9287 Usual Residence of Decedent 10c, City, Town or Location 10b. County 10d. Inside City Limits 10a State 1 ☐ Yes 2 No MD Anne Arundel Severn Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 605 Sand Road 21144 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married XX Married 1 ☐ Yes 2\times No Specify: Specify. White Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Korean 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Freight Handler Grain Elevator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lee Burgess Linda Ellis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 605 Sand Road, Severn, MD 21144 Beulah Burgess (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2XX remation 3 Removal from State 8-30-2005 ` 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A Datail 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Non lung cancer Stage TV Physician -small cell 5 months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury b Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown n signed by th 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Deen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has e 2 page certificate the Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Injury 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours af To the Funerel D 29a. Certifie l 🗶 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0035363 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BVAMC N. Greene Baltimore, M'S andra 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 3 1 2005

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygie 2005 30206 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** 28. 2005 Larry H. Brace /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** T. AGNES BALTIMORE HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Yrs Director 376-28-5934 76 2-19-1929 Michigan Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Tyes 2 Table Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 717 Maiden Choice Lane, ST521 21228 USA 12. Was Decedent Ever in U.S. Ammed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1950–54 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene. 1 Never Married 2 N Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Goddard Space Flight Elementary/Secondary (0-12) College (1-4or 5+) Physicist Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude Harold Brace Mildred Roach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum <u>once.</u> Patricia A. Brace/ Wife 717 Maiden Choice Ln., ST521, Catonsville,MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-3-05 Edgewater, MD Kalas Crematory 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Rupturd Onset and Death Immediate Cause (Final Aortic Aneurysm **Physician** Moracic disease or condition resulting in death) leas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician does detached for use as the hural Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð HOME Anourysm Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Othknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ✓ 10 After this certificate has autopsy 200 No 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 🗌 Inpatient 2 Proutpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Matural 5 Pending within 24 hours after death. To the Funeral Director: A 2 Accident investigation 1 Yes 2 No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie pletely (Check only one) 29c. License number 000 5760 92 29d. Date signed (Month, Day, Year)
Arguit, 78, 20 29b. Signature and title of certifier dana Marn M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Coton Avenus Boltmon, Mayland dana Mann 31. Date filed (Month, Day, Year) 32. Asstrar's Signature State AUG 3 1 2005 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

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ı	Physici	an	1. Decedent's Name (First, Middle, Last)				imodic or	Dodin	2. Date of Deat Month	th Day Year	3. Time of Death
	/Medic	al	John Blair 4a. Facility Name (If not institution, give s	troot and number			4h City Town	or Location of Death	Septem	ber 4, 200	
	Examin	er	Frederick Villa N		me		•	onsville		Baltin	
Ħ	Funeral		5. Social Security Number 6. Sex	7. Age		st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	0.0	hplace (State or Foreign
	Director		710-09-7147 Usual Residence of Decedent	M 2□F	84	Yrs.	Months Days	Hours Min.	Jun 2,	1921 Wes	t Virginia
	Marylan a-f show	ctor	10a. State 10b. County Maryland		10c. City,	Town or Lo	cation	Baltimore	e		10d. Inside City Limits 1 Yes 2 No
	h with the 23a or 28 at be not	Funeral Director	10e. Street and Number 2603 Carroll Stre	eet			10f. Zip Code	21230	1	0g. Citizen of What Co USA	ountry?
30	be filed within 72 hours after death with the Maryland at Hygiene. A constitution of other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Madical Examinar must be notified at	by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces ? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Decedent of I f Yes, specify Cub	dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
Ş	tural E	edt	15. Decedent's Educ	cation		16a. Dece	ient's Usual Occup	pation		16b. Kind of Business	Industry
9500-61212	within 72 ene. than "na the Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5-	+>		kind of work done DO NOT use retire enter &	during most of worki d) Welder	ing	Railroa	ıd
0	D 9 8 0	To Be Co	17. Father's Name (First, Middle, Last) Earl Blair					18. Mother's Name Maude	(First, Middle, I	Maiden Sumame)	
E.	유민들		19a. Informant's Name/Relationship (Type Shirley Armacost,	•	•					, City or Town, State, 2 ster, MD 21	· ·
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	ne Hospit. n 24 hours ne Funara	Medical C	29a. Certifier 1 certifying Physical Check only one) 2 Medical Examin	sician: To the best of ner: On the basis of and manner sta	examination	rledge, deati on and/or in	n occurred at the ti vestigation, in my o	me, date and place, opinion, death occurr	and due to the ca	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within To the Comp	M	29b. Signature and title of certifier	A	,		29c. Licens	se number	2	9d. Date signed (Mont	h, Day, Year)
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Γ	Sta Registi		31. Date filed (Month, Day, Year) SEP 0 7 2	32. Recontra	ar's Signatu		hav.				

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of Vital Records, P.O. Box	or Attanding Physician: The law requires that the death certificate be executed titler death. Stractor: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	edical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a d. C. Due to (or as a d.	a consequence of): a consequence of): of pregnancy 2 Fetal death time of death at not resulting in th at not resulting in th or year) 28b. Tim Inju or At home, farm c. (Specify) of my knowledge, a examination and/or ted.	te underlying cause given 2 attent 3 DOA Other: attent 3 DOA Other: 28c. Injury at Work? M 1 Ye: 4 street, factory, office 29c. License in DOA 29c.	26. Place of Death /C/r 4 Pursing Home at 28d. ss 2 \(\text{No} \) 28f. date and place, and nion, death occurred a number	1 Yes 24a. Was an autopsy performed to the causit the time, date	Month 2 No 3 Pro 24b. Were aut prior to ci death? 1 Yes 6 Other (Special injury occurred and Number or Ruitate) e(s) and manner as and place, and due Date signed (Month	the cause of death? the cause of death? bably 4 □Unknown topsy findings available ompletion of cause of 2 □ No sifty) ral Route Number, stated. to the cause(s)		
of Vital Records, P.O. Box	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a d. C. Due to (or as a d.	a consequence of): a consequence of): of pregnancy 2 Fetal death time of death at not resulting in th at not resulting in th or year) 28b. Tim Inju or At home, farm c. (Specify) of my knowledge, a examination and/or ted.	titent 3 DOA Other: 28c. Injury al Work? M 28c. Injury al Work? 1 Ye. 4 street, factory, office	26. Place of Death /C/r 4 Pursing Home at 28d. ss 2 \(\text{No} \) 28f. date and place, and nion, death occurred a number	1 Yes 24a. Was an autopsy performed to the causit the time, date	Month co use contribute to 2 No 3 Pro 24b. Were aut prior to co death? 1 Yes a 6 Other (Special njury occurred and Number or Run tate) e(s) and manner as and place, and due	the cause of death? the cause of death? bably 4 □Unknown topsy findings available ompletion of cause of 2 □ No sifty) ral Route Number, stated. to the cause(s)		

		_	1 - For State Registrar Americal Item #8 1. Decedent's Name (First, Middle, Last)	tate of Maryl	and / Departure 1975	artment	of H	ealth a Death	and M		1109.110.	5	30209
	Physici /Medic		1. Decedent's Name (First, Middle, Last) SHIRLEY LEE MARG							2. Date of De Month AUGUST	28 ^{Day} 2005	Year	3. Time of Death 1:35 AMM
	Examin		4a. Facility Name (If not institution, give street 9 WEST GEORGE STREET	_	A			Location o			4c. County o		
	Funeral Director		212 30 2733	^{7.} Age (In)	rs. last birthday) Yrs.	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bir Month Da JUNE	th 1934 Y 4, 1924	9. Birthp	lace (State or Foreign
	show	J.	Usual Residence of Decedent 10a. State 10b. County CARDATIANTO		City, Town or Lo	ocation MINSTE	7D					1	0d. Inside City Limits 1 XXes 2 □ No
	th the M or 28a-f	Director	MARYLAND CARE 10e. Street and Number		VIII.	10f. Zip (Code				10g. Citizen of Wi		ntry?
	eath wi	Funeral D	9 WEST GEORGE STREET 11. Marital Status 12.	APT. 1A Was Decedent Ever in	n II S 13		157	spanic Orio	nin? (Sne	cify Vas or No	UNITED		
980	d within 72 hours after death with the Maryland jene. Ir then "natural", or Items 23e or 28e-f show It's Modical Exit of attrast termilling at	by	1 Never Married 2 Married 3X Vidowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		If Yes, speci		Specify:	, Puerto F	cify Yes or No Rican, etc.)	Black Specify:	White,	etc.
21215-0036	n 72 ho	leted	15. Decedent's Educat (Specify only highest grade co	on ompleted)	16a. Dece (Give	dent's Usual kind of work DO NOT use	i Occupa k done d	ition uring most	of working	ng	16b. Kind of Bus	ness/Ind	lustry
212	ed within ygiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		MEMAKT	ER				DOMES		
Maryland	be fill tal H id oth avan	To Be	17. Father's Name (First, Middle, Last) ERNEST EDWARD BURKE								Maiden Sumame FKRAUCH)	
Mary			19a. Informant's Name/Relationship (Type,								er, City or Town, S		Code)
re,	permit. Pages 1 and 2 Department of Health a Importent: If itam 27 is any injury or othar tree once.		HARVEY B. BURROUGHS, 20a. Method of Disposition	20	b. Place of Dispo cemetery, crei	sition (Name	e of			ADENA,	MD 2112 20c. Location - C		wn, State
altimore,			XXBurial 2 □ Cremation 3 □ Rem '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	LC Coval from State	RRAINE	PARK (CEME	TERY		/2005	BALTIMO	RE,	MARYLAND
Ba	Depa Impo any i	-	Lust R. 1	Subo	MY		JRBO	RAW F	UNER	AL HOME	E, P.A. STER, MD	211	157
	Prysician /Medical Examiner	nlner	23a. Part. Enter the disease, or complicat shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	Due to (or as a con:	inc Cr	NCCC		g, such as	cardiac oi	r respiratory ar	rrest,		Approximate Interval Between Onset and Death
68760,	death certificate be executed e attending physician and ind for use as the burial-transit	edical Examine	that initiated events c resulting in death) Last d	Due to (or as a cons	sequence of):								
.O. Box		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknow	If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3 [Ectopic pre Other (spe					23d. Date Monti		ry Day Year
rds, P	sigr sigr d be	by	Part II. Other significant conditions contrib	outing to death but not	resulting in the u	nderlying ca	use give	n in Part I.			obacco use contrib /es 2 \square No 3	ute to th	. .
Vital Records,	The ate h page	e Completed	25. Was case referred to medical								rmed? de: 2 No 1	or to con ath?	osy findings available inpletion of cause of 2 No
of Vit	Physician: this certificanal director,	To Be	examiner? 1 Yes 2 Yo	1 L Inpatient 2	P ☐ ER/Outpatier			r: 4 🗆 Nur	sing Hom		dence 6 □Other)
ion	ding h. After fune	ation:	27. Manner of Death 1 Satural 5 Pending 2 Accident investigation	28a. Date of Injury (Мопth, Day Year	28b. Time of Injury	28 M	lc. Injury Work 1 Y	at ? 'es 2 □ N		8d. Describe h	now injury occurred		
Division		ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory,	office		2	8f. Location (S City or Tow	Street and Number vn, State)	or Rurai	Route Number,
	To the Hospital or Al within 24 hours after To tha Funaral Dirac completely filled in by	edical C	29a. Certifier (Check only one) Check only one)	an: To the best of my On the basis of exam and manner stated.	knowledge, death ination and/or in	n occurred a vestigation, i	t the time	e, date and inion, deat	d place, a	nd due to the d d at the time, d	cause(s) and manr date and place, an	er as sta d due to	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and the of certifier	Vanto	- MT		License				29d. Date signed (
	NK		30. Name and address of person who comp	I ted cause of death (I	Item 23a) (Type,		353		2000 W	33 65-24	8 28 2	100	`
	Sta	te.	30. Name and address of person who compared to the state of the state	32. Reg trar's Si	Spature Co	uter.	otre	et (Uest	WITZ	er, MDC	0 الح	1
	Registr		AUG 3 1 20	05 Slow	· K,	Sports							

Amended Item #20b. per Funeral Director 09/06/05

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

05 cs		For State	State of M	aryland	_		lealth and N	lental Hy	- 0	005	30210	
		Registrar			Cen	tificate of	Death	1	Reg. No.	000		
Physicia	n	1. Decedent's Name (First, Middle,	Last) TOU	EN!	BAI	PANIA	ATEN	2. Date of D	eath Day	Xear	3. Time of Death	
/Medica	al	J14156141	SIEITI			Ab Ciby Tour	al anotion of Double	1 09	<u>UC</u>	County of Dea) 12:41 PM	
Examine	er	4a. Facility Name (If not institution, Sacred Hea	rt HOSP	ital		Cun	or Location of Death	nd	4c.	711eq	inu	
Funeral Director		5. Social Security Number 220-52-9426	7. Ag 1⊠M 2□F	je (In yrs. la. 56	st birthday) Yrs.	if Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of B (Month, D June	irth lay, Yea <i>r)</i> 19, 1949	9. B ii	thplace (State or Foreign ountry) Maryland	
D .		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Loc	ation					10d. Inside City Limits	
e Maryla ta-f shov	ctor		Allegany	loc. ony,	10411 01 200	alion	Lonaconing				1 ☐ Yes 2 💢 No	
th with th	ai Director	10e. Street and Number 724	Jacobs Road			10f. Zip Code	21539		10g. Citiz	zen of What C	ountry? S.A.	
deat	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	. 13. W	as Decedent of h	dispanic Origin? (Span, Mexican, Puerto	pecify Yes or N	0- 1	4. Race - Am Black, Whi		
al', or It	by Funerai	1 ☐ Never Married 2 💢 Marrie 3 ☐ Widowed 4 ☐ Divorced				□ Yes 2 No	Specify:	Specify: White				
72 ho	eted	15. Decedent's (Specify only highest			16a. Decede	ent's Usual Occup	oation during most of work	(ina	16b. Kin	nd of Business	/Industry	
d within giene. ir than "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. D	O NOT use retire	^{d)} Manager	9		7	ires	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show raumatic event, It a Medical Examinar must be notified at	To Be C	17. Father's Name (First, Middle, L	ast) Howard Broadw	ater			18. Mother's Nam	e (First, Middle Ros	e Maiden : e Marie	Sumame) Beeman		
d 2 shou th and M 7 is mar traumat	-	19a. Informant's Name/Relationship (Type, Print) Judith Ann Broadwater - Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. 724 Jacobs Road, Lonaconing, Maryland, 21539										
pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evantmer must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Cumberland Crematory Septimizes 03, Cumberland, Maryland										
permit. I Departm Importar any injur		21. Signature of Funeral Service L				Name and Addre		Home 8 Ea	st Main	St., Lonac	oning, MD. 21539	
Physician		23a. Part I. Enter the disease, of capock, or heart failure. List of Immediate Cause (Final disease or condition	complications that cause nly one cause on each l	d the death.	Do not ente	r the mode of dyi	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death	
/Medical Examiner		resulting in death)	Due to (17 s	a conseque	ence of):	INAL	. VISL	ous o	ent	ENA	on Tons	
	miner	Sequentially list conditions,										
cate be executed physician and the burial-transit	ai Examin	resulting in death) Last	Due to (or as	a conseque	uence of):							
	dicai		d									
the Hospital or Attending Physician: The law requires that the death certificate hours after death. the Funeral Diractor: After this certificate has been signed by the attending the Funeral Diractor. After this certificate be been signed by the attending the Injection, page 2 should be detached for use as	Physician/Me							3d. Date of de Month	livery Day Year			
ires that the de signed by the a I be detached f	F.	9 Unknown Part II. Dther significant condition	s contributing to death h	out not result	ing in the un	derlying cause on	ven in Part I	23a Did	tobacco us	se contribute t	the cause of death?	
ires ti signe d be c	ρ	(1/A	io contributing to docurre	out not roods	ang in the dis	denying cause gr	on are are a		18s 2		robably 4 Unknown	
w require been signature	etec	11.10an	ENSIB.	N				17		_		
The law cate has t page 2 s	Completed	MYPEILI	211310	/				24a. Wa auto pen	s an opsy ormed?	24b. Were a prior to death?	utopsy findings available completion of cause of	
ician: Th	ပို	25. Was case referred to medical	T				OS Plans of Pas	1 Tes	2 No	1 Ves	2 No	
sicia certi irecto	00	examiner?	Hospital:	ent 2 🗆 E	R/Outpatient	3□ DOA Ot	26. Place of Dea ner: 4 \sum Nursing He			Other (See	noife)	
ding Physician: th. : After this certifica funeral director, p); To	27. Manner of Death	28a. Date of Inju	Jry 2	8b. Time of Injury	28c. Inju	ry at	28d. Describe			icity)	
utending death. ctor: Afte y the fune	ation	1 Natural 5 Pending investig	M 1□	rk? Yes 2 □ No								
al or Attend after death I Diractor: / d in by the f	Certification:	3 Suicide 6 Could n 4 Homicide determin	and 286. Place of in	jury - At hon tc. <i>(Specify)</i>	ne, farm, stre	et, factory, office		28f. Location City or To	(Street and wn, State)	Number or R	ural Route Number,	
To the Hospital within 24 hours a To the Funeral Completely filled	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medicel E	Physicien: To the best xeminer: On the basis of and manner st	of examinatio	ledge, death on and/or inve	occurred at the ti estigation, in my	me, date and place, opinion, death occur	and due to the red at the time	cause(s) a , date and	and manner a place, and du	s stated. e to the cause(s)	
To the within To the comple	Me	29b Signature and title of certifier	11		nn	29c. Licens	se number		29d. Date	signed (Mon.	h, Day, Year)	

5+VA

Division of Vital Records, P.O. Box 68760,

and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
SEP - 6 2005

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiens, Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month 2:30 PM 2005 4b. City, Town, or Location of anor Nyrsing 80 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 □ No 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubas, Mexican, Puerto Rican, etc.) 11. Maritel Status Armed Forces? 1 ☐ Yes 2 ☑ No Black, White, etc. 1 Newer Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Detes: 1□ Yes 2☑ No 3 Widowed 4 ☐ Divorced Black 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) 17. Father's Neme (First, Middle, Last) Name (First, Middle, Maiden Sumame) Daughter Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug. 24,2005 21. Signature of Funeral Service Licensee Immediate Cause (Final disease or condition resulting in death) METASTATIC CANCER VAKNOWN ORIGIN I YR -Due to (or es a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 Unknown DEMENTIA 1 ☐ Yes 2 ☐ No

Physician/Medical Examiner Division of Vital Records, P.O. Box 68760 Be Completed by Medical Certification: To

Physician

Examiner

Funeral

Director

Baltimore, Maryland 21215-0020

/Medical

Funeral Director

۾

Be Completed

injury

Physician

nvicaicai

Examiner

		24a. Wes en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
		1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical	26. Place of i	Death (Check only one)
examiner? 1 ☐ Yes 2 XNo	Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🗡 ursin	g Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Menner of Deeth 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury M 28c. Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined		28f. Location (Street and Number or Rural Route Number, City or Town, Stete)
29a. Certifier (Check only one)	nysician: To the best of my knowledge, death occurred at the time, date and planner: On the basis of examination and/or investigation, in my opinion, death or and manner stated.	ace, and due to the cause(s) and manner as stated. ccurred at the time, date and place, and due to the cause(s)

To the Hospital or Attendir within 24 hours efter death.

To the Funeral Director: At completely filled in by the fu

511

State Registrar

29b. Signature

2005

LUD D3/136 AUGUST12, 2005

ALLBLIDE RD, BALTIMONOS, BA

DHMH 16 Rev 6/95

			For State Registrar	State o	f Marylan		artmen rtificate			and M	lental Hyç	giene neg. NO	005	302	212
ż	Physicia		1. Decedent's Name (First, Middle RONALD B	RANTLEY	,						2. Date of Dea Month AUGUST	Day	Year 2005	3. Time o	Death
	/Medic Examin		4a. Facility Name (It not institution, University of Man	give street and nur	nber)	nter	4b. City. Bal-	Town, or	Location o	of Death	27-1000	4c. Co	unty of Death		
1	Funeral Director		5. Social Security Number 219–38–2804	6.Sex 10XIM 2□F	7. Age (<i>In yrs</i> .	last birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birtl (Month, Day 5/11/1!	r, Year)	Cou	place (State ntry) yland	or Foreign
	ne Maryland 8a-f ehow	ctor	2	mico		y, Town or La	сy					40. 00			ity Limits
	with the		10e. Street and Number 121 North Park	Drive			10f. Zip	1804				10g. Citizen USA	of What Cou	ntry?	
00	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, The Medical Examination in must be multiled at an ance.	by Funeral Director	11. Marital Status 1 □ Never Married 2 Marri 3 □ Widowed 4 □ Divorced	12. Was Dec	2 📉 No ⁄e	.S. 13.	Was Deced	dent of Hi cify Cuba	spanic Orig n, Mexican Specify:	gin? (Sp i, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Amer Black, White		
00-61	in 72 hour n "natural	Completed b	15. Decedent (Specify only highes	's Education t grade completed)		(Give	dent's Usua kind of wo DO NOT us	rk done d	furing most	t of work	ing	16b. Kind	of Business/Ir	ndustry	
7 7	giene grene	Com	Elementary/Secondary (0-12)	College (1-40(5+)	Mecha	anical	LEng					strial	Plant	
/and	uld be file Mental Hy irked oth	To Be (17. Father's Name (First, Middle, Kenneth Brantl								e (First, Middle, aughert		mame)		
, Mar)	end 2 sho lath and l n 27 is ma		19a. Informant's Name/Relations Bonnie Brantley			121	North	ı Par	k Dr		a <i>l R</i> oute Numbe alisbur Date	y, MD	21804		
Поге	Pages 1		20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other (S)		State	cemetery, cre	matory or o	ther plac	Θ)		/05				
рапшо	permit. Depertrainmonts eny inju		21. Signature of Funeral Service	Licensee 1 4 M CF	SP	Î	2. Name ar	vay I	s of Facility	ăl H	ome Pro: Salisb	fessio	onal As	ssocia	tion
9/00,	Physician personned did by Medical physician and interest	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Aur Due to	(or as a consector as	eno \$ 1 quence of):		vecy,	Sym	dn	ne			7 40	ears
O. Box 62	death certific e attending p id for use as	Physician/Med	60								23d	Date of deline	ery Day	Year	
ds, P.	law requires thet the de es been signed by the a 2 should be detached t	Ď	Part II. Other significant condition	ons contributing to c	eath but not res	sulting in the	underlying o	ause giv	en in Part I			obacco use	contribute to		death? Unknown
Hecords,	The ete h page	Completed											4b. Were aut prior to c death? 1 \(\sum Yes	ompletion of	s available cause of
Vital	icien: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:	_			Oth			h (Check only o				
on of	sing Phy J. After this funeral d	lon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	28a. Date (Mor		28b. Time Injury		28c. Injur Wor	y at		ome 5 Resident			ify)	
Division of		Certification;	2 Accident investig	not be 28e. Plac	e of Injury - At h ling, etc. (Speci	ome, farm, s					28f. Location (S City or Tox		lumber or Ru	al Route Nu	n <i>ber</i> ,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical C		ng Physician: To th Examiner: On the I and man											(s)
	vithii To th	Me	29b. Signature and title of certifie	7					e number				igned (Month	-	
	B		30. Name and address of person	who completed cau	se of death (Ite	m 23a) (Type	, Print)	P	186	00	al-fimor	Augu	st 27	, 20	05
	3	oto	Jeffrey Live 31. Date filed (Month Pay Year)	/	22 gistrar's Sign	South ature	Gre	ene	St,	Bo	altimor	e, N	10 2	1201	
1	Regist	ate rar	SEP 0	1 2005	Robert	N. 1	bark	9							

State of Maryland / Department of Health and Mental Hygiene 30213 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Pearne Bryson August 2005 0146 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Peninsula Regional Medical Center Salisbury Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 🛛 M 2 🗆 F 224-60-0210 Director 94 6/12/1911 California Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 Is marked other then "neturel", or Items 23e or 28e-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1103 S. Schumaker Dr., Apt. 309 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2X No Specify 3 XWidowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Geologist 4+ Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter Bryson Harriett Pearne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Robert Bryson/son 31619 Zion Rd., Parsonsburg, MD 21849 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of HImportant: If iter
any injury or oth 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 9/1/05 Salisbury, MD 22. Name and Address of Facility Holloway Funeral Home Professional Association 21. Signature of Funeral Service Licens 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Aspiration pneumonia disease or condition resulting in death) 24 hours /Medical Due to (or as a consequence of): **Examiner** Congestive Heart Failure 10 years Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š 1 Yes 2X No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate has 2∏ No Division of Vital 1 Yes 2 No 1 TYes To the Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 2 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After ! Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funerel C 29a. Certifier 🛛 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D54127 9/1/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Alon Davis 100 Power St., Salisbury, MD 21804 31. Date filed (Month Day Year) Pagistrar's Signature State 1 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 - For State Ragistrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle, Last) Month Day 5:45 **Physician** September 6, 2005 James McGuire Beaver, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's 22977 Oakley Road Avenue If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months 187M 2□ F Yrs. 55 Director 214-52-2724 November 7, 1949 Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo St. Mary's Avenue Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 22977 Oakley Road 20609 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or item any injury or other traumatic event, the Mexical Experiments." Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: ρ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Program Manager U.S. Government 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Kelso Farrell Beaver 2 Agnes Minnett Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ruth Ann Beaver / Wife 22977 Oakley Road, Avenue, Maryland 20609 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition September 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10, 2005 Sacred Heart Cemetery Bushwood, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 Thichael feets 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acuk Physician Mylord Leukemia lyear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Examiner as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 4☐Pregnant at time of death ed by the a detached f Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part fl. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 No Division of Vital : After this certifice funeral director, t or Attending Physician: 25 Was case referred to medical Be 26. Place of Death (Check only one, examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pendina 1 Yes 2 No within 24 hours after death. To the Funerel Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospitel 29a. Certifier 🚝 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 50686 9/3/05

Registrar

State

31. Date filed (Month, Day, Year) Registrar's Signature 8 2005 SEP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

25500

asu

GURDEEPS, CHIPAGERA



MD 20650

Leonard foun

State of Maryland / Department of Health and Mental Hygier 005 30215 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 7:15 a^M Kenneth Henson Bradford, Sr. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 26817 Hidden Acres Court Mechanicsville Mary's St. If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Aug. 3,1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months 1 € M 2 □ F Director 514-09-0808 86 Kansas Usual Residence of Decedent Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event. The Medical Examinar must be notified at 1 □Yes 2 No Director Mechanicsville Maryland St. Mary's the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20659 26817 Hidden Acres Court United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after 2 □ No 1942-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 PNo Specify: Specify: White þ 1945 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 12 should be filed wi h and Mental Hygien 7 is marked other th Deputy Marshall U.S. Marshall 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Henson Bradford Clara Saylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sinent of Health an Caroline B. Bradford / Wife 26817 Hidden Acres Court, Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ō permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Epiphany Ch. Cemetery Sep.9,2005 Forestville, Maryland 21. Signature Juneral Service Licensee 22. Name and Address of Facility Brinsfield-Echols Funl. Hme., P.A. Edward N. Brinsfield M00052 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stage Pnysician Parkinson's /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and ре ехесп Due to (or as a consequence of) attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. heart estrue 1 Yes 2 No 3 Probably 4 Unknown Completed supprogeal 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed nenal 2 No 1 Yes 2 No 1 ☐ Yes Chunoc leral Director: After this certific filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) H0055751 30. Name and wiss of person who completed cause of death (Item 23a) (Type, Print) Jennifer Schmidt, D.O., 23415 Three Notch Road, California, Maryland 20619 31. Date filed (Month, DSEP 2005 Regis State Registra

				artment of Health al		Reg. No.	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Patricia Ann Brandon		2. Date of De Month August	25, 2005	3. Time of Death 1802 P M
	Examin		4a. Facility Name (If not institution, give street and number) Prince Georges' Hospital	4b. City, Town, or Location of Cheverly	Death	4c. County of Death	h
	Funeral Director		5. Social Security Number 6. Sex 1	If Under 1 Year If Under 2 Months Days Hours	4 Hrs. 8. Date of Bi Min. (Month, Da 02/12	ay, Year) Co.	nplace (State or Foreign untry) rginia
	aryland show	<u>_</u>	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28e-f	Director	D.C. Washi	10f. Zip Code		10g. Citizen of What Co	
	3a or	l Dir	4508 Eads Place, N.E.	20019		U.S.A.	unity:
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic avant, Ite Medical Examination institution at 2000.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Yes 1 Yes 2 Yes 1 Yes 7 Yes 1 Yes 7 Yes	Was Decedent of Hispanic Origi If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 No Specify:	in? (Specify Yes or No Puerto Rican, etc.)	o- 14. Race - Amer Black, White	
Maryland 21215-0036	n 72 ho "natur edical	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of DO NOT use retired)	of working	16b. Kind of Business/I	ndustry
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nd	be filed tal Hygir d other avant, I	Be	17. Father's Name (First, Middle, Last)		's Name (First, Middle		
<u> </u>	should be and Mental and Mental and marked o	4	Olander Brandon		Roxie Ferg		
ā	id 2 st ith and 27 is n traun		1.1.1.	ing Address (Street and Number 36 First Street			
Baltimore,	Pages 1 and 2 nent of Health int: if item 27 inty or other tre		20a. Method of Disposition 1 □ 8urial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, cn	osition (Name of ematory or other place)	Date 8/31/2005	20c. Location - City or Washington	Town, State
Balti	permit. Departri Importa any inju		21. Signature of Fineral Service License	2. Name and Address of Facility P. O. Box 416; Sui			
	3/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	1) Cancer			Onset and Death
ŀ	/Medical Examiner		Due to (or as a consequence of):				
	D :	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury				
90,	ificate be executed g physicien and as the burial-transit	ıl Examiner	Cause (Disease or Injury that initiated events resulting in death) Last C				
68760,	ficate t g physical as the b	edlcal	d				
Вох	To the Hospitel or Attanding Physician: The law requires that the death certi within 24 hours after death. To tha Funaral Diractor; After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/M		□Ectopic pregnancy □ Other (specify)		23d. Date of deli- Month	very Day Year
rds, P.	quires that en signed b	by	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did 1	tobacco use contribute to Yes 2 \(\text{No} \) 3 \(\text{Pro}	the cause of death?
Vital Records, P.O.	The law re ate has being page 2 sho	Completed			24a. Was auto perfo 1 \(\text{Yes}	psy prior to cormed? death?	topsy findings available ompletion of cause of
Vita	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Other	of Death (Check only		
	Physic this eral dis	. To	27. Magner of Death 28a. Date of Injury 28b. Time	at 3 DOA 4 Nurs	All regions and the second	idence 6 Other (Spec how injury occurred	ify)
ion	ath. r: Afte re fune	atlor	1 Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	0		
Division of	after de Diracto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office		Street and Number or Rui wn, State)	ral Route Number,
	To the Hospitel or Attanding Physician: The law within 24 hours after death. To tha Funaral Diractor: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and nvestigation, in my opinion, death	place, and due to the occurred at the time,	cause(s) and manner as date and place, and due	stated, to the cause(s)
	within To the comple	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month	
	^		Chilex 5 Deces	() 2914	15	08.3	0-05
1	2/2)	30 Name and address of person who completed cause of death (Item 23a) (Type Charles Boice	Print) TINCE GEORGES!	Hospital:	Cheverly, M	
	Sta Registr	_	31. Date filed (Month, Day, Year) AUG 3 1 2005	Print) Conce Georges!		O'	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiegen 05 1 - Stata Registra Certificate of Death Rag. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month 29 2005 Bachmann August 8:30 P M Constance Una /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolitan Assisted Living Annapolis | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Nov. | 1, 1912 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Wash., D.C. 6. Sex **Funeral** 1 □ M 2 💆 F 92 579-03-8769 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "netural", or items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Crofton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1514 Farlow Ave. 21114 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: withIn 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed withln al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Medical other treumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent; if Item 27 is marked othe any injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Franklin Pierce Henrietta Ramsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles W. Bachman / Crofton, MD. Farlow Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery ^ 4 □ Donation 5 □ Other (Specify) 109/02/2005 Suitland, MD. 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy. Bowie, MD. 1 ar 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Dementa work down /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 mon 1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9☐ Unknown 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 ☐ No 1 Yes funeral director, 25. Was case referred to medical Assisted 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Injury 5 Pending Natural r death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 05 Md. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ton Crofton Medical Center

ay, Year)

12. Registrar's Signature 1667 Mirza Nusairee, M.D. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State AUG 3 1 2005 Registra DHMH 17 Rev 1/2001

		1 - For Unpend Item 2 Registrar	State of Maryla 3a&27 per me	G847 Ce	artme rtifica	05° t te of l	ealth a S Death				200	
Physici	an	Decedent's Name (First, Middle, Last)	DD OLDS						Date of Deat Month	Day		3. Time of Death
/Medic	al	SHIRLEY 4a. Facility Name (If not institution, give s	BROWN		4h Cih	Tour or	Location of		SEPTEME		2, 2005 County of Dea	
Examin	er							or Death			INCE GI	
Funeral		PRINCE GEORGES HOS 5. Social Security Number 6. Sex		. last birthday)	If Unde	EVERI er 1 Year	If Under	24 Hrs. 8	Date of Birth	Year	9. Bir	thplace (State or Foreign
Director		579 – 06 – 0270 ¹₽	M 2□F 45	Yrs.	Months	Days	Hours	Min. AU	Date of Birth Month Day, IGUST I	$0^{\theta ar}$	1960 ที่ยี่	WYORK, NEWYO
D >		Usual Residence of Decedent 10a. State 10b. County	100.0	ity, Town or Lo	ocation							10d, Inside City Limits
aho	ច	D.C.		WASHING								Yes 2 No
28a-f	ect	10e. Street and Number		WIDITING		ip Code			1	0a. Citi:	zen of What Co	ountry?
be filed within 72 hours after deeth with the Maryland tal Hygiene and Hygiene do the Hygiene do the Hygiene abovent, the Modical Exaction must be notified at	Funeral Director	5216 ASTOR PL.,	S.E.			2001	.9			_	ITED ST	,
deeth	nera	11. Marital Status	2. Was Decedent Ever in t Armed Forces?	J.S. 13.	Was Dec	edent of H	ispanic Ori	igin? (Specif	y Yes or No- can, etc.)		14. Race - Ame	
or its		1 Never Married 2 Married	1 ☐ Yes 2 7 No	- (1 □ Yes	17	Specify:		A11, 610./		Black, Whi Specify: B	LACK
72 hours aft	d by	3 Widowed 4 Divorced	Year or Dates:	1 10 2								
n 72	lete	15. Decedent's Educ (Specify only highest grade	completed)	16a. Dece (Give	kind of w	uai Occupi ork done d use retired	durina mos	it of working		160. Kil	nd of Business	rindustry
with in the control of the control o	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)				HOTE	EL WOR	KER		HOTEL	
2 should be filed within 72 had and Mental Hygiene. Is marked other than "nature aumatic avent, its Muchical	BeC	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name (F	irst, Middle, M	Maiden	Sumame)	
	70 E	GEORGE P. BROWN					RUTI	H GUI	NYARD			
s 1 and 2 should if Heelth and Men then 27 is marke other traumatic		19a. Informant's Name/Relationship (Type	•								Town, State,	
and feelth m 27 her tr		DEMETRUIS BROWN/SO	Andrewson to the second	521 Place of Dispo			L., S	S.E. W			D.C.	
Pages 1 hent of H int: If ite		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ R		cemetery, cre	matory or	other plac	e)	Dan	•	20C. LU	cation - City or	Town, State
it. Partiment		4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service License		OLIVE			S of Facilit	9-9-05	CA	PYA	HINGTO	NARD.C.
permit. Pages 1 and 2 Department of Heelth 6 Important: If Item 27 I. any Injury or other tra		MANNOR	was the los					Breeze to	NEW	A SH	ENCTON	D.C. 20002
		23a. P. 1. Enter the disea or complices lock, or heart failure. List only on	cations that coused the de								indion,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Cardiac Dil									Onset and Death
/Medical		resulting in death)	Due to (or as a conse		-							
Examiner		Sequentially list conditions.										
sit 9d	iner	Sequentially list conditions, if any, leading to increase a cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consa	quenne of):								
be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conse	quence of):								
Sicien Suria	calE											
fficate p phys												
anding use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregr 1 □Live birth 2 □ Fet							2	3d. Date of de	livery
death death	icia	in the past 12 months? 1,□Yes 2□No	4☐ Pregnant at time of		Other (pregnancy specify)					Month	Day Year
et the 1 by th	Phys	9 Unknown										
res th signed be d	δ	Part II. Other significant conditions con	tributing to death but not re	sulting in the t	anderlying	cause give	en in Part I	l.		s 2		o the cause of death?
w requir been si	eted								-			
e law has t	Completed								24a. Was at autops perforn	y	24b. Were at prior to death2	utopsy findings available completion of cause of
r:Th				-71					1 Yes 2	2 □ No	1 Yes	2 □ No
sicial certii irecto	o Be	25. Was case referred to medical examiner? 1 TXYes 2 No	ospital: 1 ☐ Inpatient 2 X	☐ ER/Outpatie	ot 2 🗆 [Oth	or		Check only on		i □Other (Spe	
erald	1	27. Manner of Death	28a. Date of Injury	28b. Time o		28c. Injun Worl			d. Describe ho			City)
Attending r death.	atio	14 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	М		Yes 2	No				
r Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		reet, facto	ry, office		281	Location (St. City or Town			ural Route Number,
urs eff												
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours eiter death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be deteched for use as the	Medical		sician: To the best of my kr par: On the basis of examinand manner stated.									
ro the vithin ro the complex	Me	29b. Signature and title of certifier	/ A.		2	9c. License	e number		25	9d. Date	signed (Mont	h, Day, Year)
.00		May ho	yould n	W		0.C	.M.E.		SI	EPTE	MBER 3	,2005
20		30. Name and addless of person who co										21.001
		TAMYDIAN D. 1	Lorde		111	PENN	STREE	ET BAL	TIMORE,	, MAR	YLAND 2	21201
Sta Regist		SEP 0 9 2005	32. Registrar's Sign	nature								

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ORIGINAL

			State of Maryland / De	epartment of Health and Mental H	ygiene 2005 30219
			1 - State Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	1109.110.
	Physicia		Mae Julia Blake	Month	Day Year
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Montgomery Co.Hospital	Olney	Montgomery
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	day) If Under 1 Year If Under 24 Hrs. 8. Date of E Months Days Hours Min. (Month, I	9. Birthplace (State or Foreign Country) Maryland
	ס	}	Usual Residence of Decedent	000	13,1927 Maryland
	arylan show	7	D.C. 10b. County 10c. City, Town of Washir		10d. Inside City Limits
	the M	ecto	D.C. Washir	19 LOT1 10f. Zip Code	1√2 Yes 2 □ No 10g. Citizen of What Country?
	3a or	Funeral Director	2820-27th St,N.E.	20018	U.S.A.
	ms 2	nera		Was Decedent of Hispanic Origin? (Specify Yes or I If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
36	d within 72 hours after death with the Maryland Jiene. r than "natural", or items 23a or 28a-f show the Modical Examinational be notified at	by Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ☑ No Specify:	Specify:Black
21215-0036	2 hour	ed b		ecedent's Usual Occupation	16b. Kind of Business/Industry
215	within 72 ene. than "na	Completed	(Specify only highest grade completed) (In the secondary (0-12) College (1-4or 5+)	Give kind of work done during most of working ife. DO NOT use retired)	Dept of
	il Hygian other th		12th Dat	a Entry	Transportation
Maryland	ed is a) Be	17. Father's Name (First, Middle, Last) Stanley E.Franklin	18. Mother's Name (First, Middle Peggy Cook	lle, Maiden Surname)
ary	2 should be and Menta 1s marked eumetic ev	To		Mailing Address (Street and Number or Rural Route Num	nber, City or Town, State, Zip Code)
	1 and 2 Health a tem 27 is		Pamela Rumph-Daughter 282	20-27st, N.E. Washingtor	
altimore,	S == = 0		Burial 2 Cremation 3 Removal from State cemetery,	oisposition (Name of crematory or other place)	20c. Location - City or Town, State
Him	t. Pa rtmen rtent: njury		'4 □Donation 5 □ Other (Specify) F'T Llr 21. Signature of Funeral Service Licensee	acoln Cem. 9-7-2005	Brentwood, Md.
Ba	Departiment of the particular		Jant C- Inderson	Dunn & Sons 5635 Eads	s St, N.E.
			23a. Part. Enter the disease, or complications that caused the death. Do no speck, or heart failure. List only one cause on each line.	. 6	Interval Between
	Physician /Medical		Immédiate Cause (Final disease or condition resulting in death)	al Heavardinge	Onset and Death
Г	Examiner		Due to (or as a consequence of)	al Heavardinge reprovessión Azerde	
	n #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	the Controvascular	P. Comments
	be executed sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c Due to (or as a consequence of)		drease
8760,	death certificate be executed e attending physicien and ad for use as the burial-transit	aiE	But to for as a consequence of		
9	tificate ig physi as the l	ledicai			
Вох	eath certific attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death	3 □Ectopic pregnancy	23d. Date of delivery Month Day Year
0.	that the desired by the aidetached to	Physician/M	in the past 12 months? 1	5 Other (specify)	Month Day Year
<u>α</u>	The law requires that the law sequires that the seen signed by the sage 2 should be detache	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I. 23e. Did	d tobacco use contribute to the cause of death?
of Vital Records,	w require: been sig should b		Deneutin	1 [Yes 2 No 3 Probably 4 nknown
ecc	e law re has be je 2 sh	Completed		24a. We	topsy prior to completion of cause of
al H		- 1		pei 1 ☐ Yes	rtomed3 death? 1 ☐ Yes 😿 No
Vit	Physicien: 1 this certificar ral director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 Wilo Hospital: 1 Impatient 2 ER/Outp	26. Place of Death (Check only	
		-	27. Magner of Death 28a. Date of Injury 28b. Tin	ne of 28c. Injury at 28d. Describe	sidence 6 Other (Specify) e how injury occurred
ion	Attending r death. sctor: After	atio	1 Natural 5 Pending (Month, Day Year) Inju 2 Accident investigation	M 1 Yes 2 No	
Division	l or Attendater death Director:	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	i, street, factory, office 28f. Location City or T	(Street and Number or Rural Route Number, own, State)
_	To the Hospitel or At within 24 hours after o To the Funerel Direct completely filled in by	O	29a. Certifier (Check only 2 Medical Examinar: On the basic of avanination and	death occurred at the time, date and place, and due to the	ne cause(s) and manner as stated.
	To the H within 24 To the Fi complete	Medical	one) and manner stated.		
	viti To		29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
n	\bigcap		30. Name and address of person who completed cause of death (Item 23a) (T)	ype, Print) GODSWILL C	OKO JI MD FACE
1-			7573 New Wangshul 1970 31. Date filed (Month, Day, Year) 22. Registrar's Signature	Talcina parle mo	20012
	Sta Registr		SEP 0 1 2005	and I	
DH	IMH 17 Rev 1/2		The same of the sa		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 30220 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day AUGUST 26, BARCLAY 2005 12:48 P M DONALD Α. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5719 ABERDEEN ROAD BETHESDA MONTGOMERY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) OCT 24, 19 Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X**]M 2□ F Director 565-40-8612 72 Yrs. 1932 CALIFÓRNIA Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Itam 27 is marked other than "natural", or Itams 23s or 28s-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show the Modical Examiner must be notified at 1 Yes 2 No MARYLAND MONTGOMERY BETHESDA Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5719 ABERDEEN ROAD 20814 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1Xi Yes 2 □ No 1954 – If Yes, Give Year or Dates: 1956 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Š 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) FACILITIES MANAGER FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PORTER BARCLAY MILDRED 2 SWANSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LYNN GARBER BARCLAY, WIFE 5719 ABERDEEN ROAD, BETHESDA, MARYLAND Sortant: If Itam 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial Cremation 3 Nemoval from State 4 □Do ation 5 Other (Specify NATIONAL CREMATORY 8/31/2005 FALLS CHURCH, VIRGINIA Funeral Service Li 21. Signa ure c 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. ensee 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Page. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fina-disease or condition resulting in death) **Physician** PROGRESSIVE GLIOBLASTOMA MULTIFORME 12 MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner and I-transit the death certificate be executed that initiated events resulting in death) Last attending physician a Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 😾 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA : After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 Yes 2 No Diractor: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Myram DQ3308 AUGUST 29, 2005 30. Name and address of person tho completed cause of death (Item 23a) (Type, Print) VICTOR M. PRIEGO, M.D., 6420 ROCKLEDGE DRIVE, SUITE #4100 BETHESDA, MD 31. Date liled (Month, Day, Year) 32. Megistrar's Signature State 2005 AUG 31 Registrar

State of Maryland / Department of Health and Mental Hygien 2005 30221 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year John Joseph Barry August 28,2005 10:05am ^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 4004 Manor Rd Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1₹M 2□F 099-16-5914 Yrs. Director 81 May 19,1924 Syracuse, NY Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injuryed other traumetic event, the Medical Examinar must be notified at anone. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Montgomery Chevy Chase 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4004 Manor Rd 20815 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 3-6-44
14 Yes 2 No -26-46 Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) President Labor Union 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Aloysius Barry Mary Brody 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kitty Barry/ Wife 4004 Manor Rd, Chevy Chase, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 8-31-05 Silver Spring,MD ^¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Paris Sons, Inc 21. Signature of Funeral Service Licensee West Where 5130 Wisconsin Ave, N.W. Washington DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Asbestosis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 200 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 1 Yes 1 Yes 2 \ No 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 1 ☐ Yes 2X No Certification: To 4 ☐ Nursing Home 5 MResidence 6 ☐ Other (Specify) Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 Tes 2 No 2 Accident investigation filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Att within 24 hours after d To the Funeral Direct 4 Thomicide 29a. Certifiei Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) D33554 August 30,2005 use of death (Item 23a) (Type, Print) Name an address of person with John E. 5410 Connecticut Ave, N.W. #117 Washington DC 20015 Date fied (Month, Day, Year) 32 Registrar's Signature State

Registrar

AUG 3

2005

State of Maryland / Department of Health and Mental Hygiene 0 0 5 30222 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 31, JAMES EVERETT BURKE 2005 August 11:51 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 236 East Sixth Street Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1∏ M 2□ F Months Yrs. Director 220-54-4098 54 19 1950 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10h Counts 10d. Inside City Limits or 28a-f show other treumatic event, the Medical Examiner must be notified at 1.☐Yes 2☐No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 236 East Sixth Street items 23e 21701 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after tent of Health and Mental Hygiene. Nnt: If Item 27 is marked other then "neturel", or Itel 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: <u></u> Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Radio TV Engineer Montgomery College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Stanford Burke Evelyn Vandling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Importent: If Item 27 is any injury or other treu once. Allen Merchant (Friend) 1606 North Market Street, Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 9/2/2005 Smithsburg, Maryland ⁴ □ Donation 5 □ Other (Specify) ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Parti. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atherocalmoti Vesceler disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dichetes Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury Due to (or as a consequence of): Examine physician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical as the IF FEMALE: esn. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. | the 9 Unknown 9 Unknown Ď signed to Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No certificate 1 Yes 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending death. 1 Yes 2 No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide n 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) MD MD51610 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Sui (conser 31. Date filed (Month, Day, Year) (32. Regist State 2005 Registrar

			1 - For State Registrar	State of Ma		Dep		Health and	,	giene		
			Decedent's Name (First, Middle, Last)			ranoate or	Dealit	2. Date of Dea	Reg. No.	005	3. Time of Death
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	/Medic Examin		4a/Facility Name (If not institution, give		OHILLI A	,		or Location of Dea		4c.	County of D	
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	Funeral Director		218-34-8622	X 7. Age	(In yrs. last bi	rthday) Yrs.	Months Days			h V. Year) 192		Birthplace (State or Foreign Country) IARY LAND
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Lo	ocation					10d. Inside City Limits
	Maryl f sho	Por	MARYLAND WORCES	red	WHALE							1 ☐ Yes 2 No
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	h with	D D	8702 WHALEYVILL	E ROAD			2187	2.			USA	
	deat	by Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13.			Specify Yes or No- rto Rican, etc.)	1	4. Race - A	merican Indian,
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lan	should be nd Mental marked c	To Be	HORACE W.	CAREY	SR.			LUCY	MAE		IORT	
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-	alth a alth a 27 ls		DOROTHY A. CAREY/	WIFE					, WHALEY	-		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: if item 27 Is marked eny injury or other treumetic es ones.		20a. Method of Disposition		20b. Place o	f Dispo	osition (Name of matory or other place		Date			or Town, State
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alt	permit. Departr Importe eny inje		21. Signature Funeral Service Licens	A //			2. Name and Addre					
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	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):						
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	181		30. Name and address of person who co									
	/		JAMES TODD, MD	201 PINE				25, SALI	SBURY, M	D 21	801	
	Sta Registra	_	SEP 0 2 20	105 32. Higistrar	's Signature	1	melle					-

William F. Cook SS # 214-30-8581 Maryland 21215-0036

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Box 68760,
P.O.
Records,
of Vital
Division

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and	*		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
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al ylal should b	Ment arkac atice	10	George Cook				Nelson		
٠ -	s and is m		19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street				ZIP Code)
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1	- 11		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li	d the death. Do not	t enter the mode of dyin	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
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7	requires mature deam agan signed by the atter hould be detached for	y Ph	Part II. Other significent conditions contributing to death to	out not resulting in t	he underlying cause gr	ven in Part I.	23e. Did tobac	co use contribute to	the cause of death?
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0	> 10 %	plete					24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
ř	ine iaw ate has b page 2 s	mo					performe 1 ☐ Yes 2 ☐	d? death?	2 □ No
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7	rnysicten: The lay this certificate has al director, page 2	은	1 ☐ Yes 2 ☐ No ☐ ☐ ☐ ☐ I ☐ Inpati		latient 3 DOA	and the same of th	ome 5 Residence 28d. Describe how		ecify)
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	To the Hospital or Attending Priysicien: within 24 hours after death To the Funerel Director: After this certifica completely filled in by the funeral director.		29a. Certifier (Check only 2 Medical Examiner: On the basis	t of my knowledge, of examination and/	death occurred at the t	ime, date and place, opinion, death occur	and due to the caus	se(s) and manner a and place, and du	s stated. e to the cause(s)
	the H hin 24 tha F mplete	Medical	and manner s			se number		. Date signed (Mon	
	5 4 K 5	1	250. Signature and title of certifier						
	9	3	30. Name and decress of person who completed cause of	death (Item 23a) (T	ype, Print)	1771	707		, -
	100		andy pierce	M.O. 1	OO E. CAL	RRO1/ 51	Sallsa	king m	20
		ate	31. Date filed (Month, Day, Year) 32. Pegist	trar's Signature	1				
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			Please					c. Ensure A Health and			-		
			1 - For State Registrar	State of	iviai ylai i	-	tificate of		wentar my	Reg. No.	11115	3022	5
	Physici	an l	1. Decedent's Name (First, Middle, La	st)					2. Date of D	eath Day	/ Year	3. Time of De	
	/Medic		VICTOR (NMN)	CERAVALO					SEPTEM		2005	102	РМ
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	with ti	급	10e. Street and Number	unmarr na			10f. Zip Code	0175/		10g. Citi	izen of What Co		
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	and 2: ealth ar m 27 is her trau		NANCY S. CERAVALO	/SPOUSE				ÆL CHURC					'56
Baltimore,	T 4 2		20a. Method of Disposition		1 0	lace of Dispo	sition (Name of natory or other pl		Date		cation - City or		
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alti	permit. Pag Department Important: I any Injury c		21. Signature of Fulleral Service Lice		1 M. D	22	. Name and Addi				ational	-	
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Records,	uires tha signed Id be dei	d b							1 🖼	Yes 2	□No 3□Pr	obably 4 Unk	nown
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Division	I or Attendi after death. Director: A I in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of building	if Injury - At ho g, etc. <i>(Specif</i>)	ome, farm, str /)	eet, factory, office	Ð	28f. Location City or To	Street and wn, State,	d Number or Ru)	ural Route Number	r,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funsral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Pl	aveisian. To the h	ont of my ken	ulodeo docti	annumed at the	time, data and plac	a and due to the				
	To the Hospital within 24 hours a To the Funsral I completely filled	Medical		miner: On the bas	is of examinat	tion and/or in	vestigation, in my	time, date and place opinion, death occ	urred at the time.	date and	and manner as place, and due	to the cause(s)	
	Vithin Fo the	₹ E	29b. Signature and title of certifier				29c. Licer	nse number		29d. Date	e signed (Montl	h. Day, Year)	
٨	> - 0		> machines (mul.		MAN	0	41667		C	7.9.0	01	
1	U2		30. Name and address of person who	completed cause	of death (Item	23a) (Type,	Print)				,	4	
1	10		Michael Mc	Corneck			ned Ecol	Comp	us It	Jer	steen	MO.	
	Sta Regist		31. Date filed (Month, Day, Year) SEP 0 9 2	005	gistrar's Signa	B. Sp	ede						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Donald Lester Clopper 3 2005 September 5:25 pm 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Williamsport Nursing Home Williamsport Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) Days 1√2 M 2□ F 220-16-0186 79 Yrs June 22 1926 Maryland Usuel Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 208 Devonshire Rd 21740 USA 12. Was Decedent Ever in U,S. Armed Forces? 14∑ Yes 2 □ No If Yes, Give Yeer or Dates: 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled Never worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clyde Clopper Bessie Renner 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 59 W. Washington St. Tammy Bender/Agent Hagerstown MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery Sept 9 05 Hagerstown MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signal Funeral Service Licenses 1601 Pennsylvania AVe Hagerstown MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) · Metastatic Skin Cancer yeal Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Due to (or es e consequence of) Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy ZILINO 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4_ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 CNaturel

Box 68760, use es ettending I Division of Vital Records, P.O. peed s certificete has t director, page 2 s director, this Aftert efter deeth. ò To the Hospital o within 24 hours of To the Funeral Di completely filled in

filled in by the

Physician/Medical Examiner

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Certification:

Medical

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Funeral

Director

r than "naturel", or items 23a or 28a-f sho the Medical Examiner must be notified at

filed within 72 hours after death with

. Peges 1 end 2 should be fill iment of Heelth end Mental H tant: If Item 27 Is marked out

important: If it any injury or o

Physician /Medical

Examiner

Maryland 21215-0020

State Registrar Cynthia - Sands M.D.

5 Pending investigation

6 Could not be determined

Cynthia Kuttner Sands no

29c. License number D47451

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) September 3, 2005

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

em 23a) (Type, Print)
Williamsport Nursing Home 154 North Artizan Street Williamsport, Maryland 21795

31. Date filed (Month, Day, SEP "0"8 2005

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene 005 30227 For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** JACK EDWARD CHANCE, SR SEPT 3 2005 0638 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8799 BLACK DOG ALLEY EASTON, MARYLAND TALBOT If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year 9-27-1939 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1**∑**M 2□F Months MARYLAND 217-36-0892 65 Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD. TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 8799 BLACK DOG ALLEY 21601 U.S.A. 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No. If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black. White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 ò 1 ☐ Yes 2X No Specify: Specify: WHITE þ 3 □ Widowed 4 □ Divorced "netural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) UTILITIES WORKER LOCAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mental MILTON R. CHANCE Pages 1 and 2 should be ment of Health and Menta CORNELIA MARSHALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GRACE ANITA CHANCE / WIFE 8799 BLACK DOG ALLEY, EASTON, MD 21601 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CHESAPEAKE CREMATION 1 ☐ Burial 2X Cremation 3 ☐ Removal from State ö 9-4-2005 STEVENSVILLE, MD. tant: injury ¹ 4 □ Donation 5 □ Other (Specify) CENTER Depa tr Importa any inj 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. M. Ostrousk Joseph 200S HARRISON STREET EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ESFIRA TORCY /Medical Due to (or as a consequence of): Examiner JO. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine (OBACCO burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical the as IF FEMALE nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy ned by the atten a detached for u Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 2 🗆 No layed to 718 certificate 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 esidence 6 Other (Specify) 25 No 1 🗌 Yes Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: the 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Homicide within 24 hours a To the Funerel C Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date sighed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOLDUBORG mours 32. Restrar's Signature 31. Date filed (Month SEY Year) State Registrar

ORIGINAL

			1 - State Unpend Registrar 1. Decedent's Name (Firs			arylan me	d / Depa G848-}/	irtment o	f Health an of Ge ath		neg. I	2005	30228
	Physic		JAMES		н .		CAD	aon		2. Date of D Month	D	ay Year	3. Time of Death
	/Medi Examii						CAR		n or Location of D	SEPT.		, 2005	0648 A M
			4a. Facility Name (If pot id 11844 ELL	LNGTON	DRIVE			BELT	SVILLE of D	odi()	Ī	RINCE G	EORGES
	Funeral Director		5. Social Security Number 241-44-3749	1	ex 7. Ag ⊠M 2□F	e (In yrs. 73	last birthday) Yrs.	If Under 1 Yo Months Da		Hrs. 8. Date of B (Month, D Februa	irth ay, Yea	1932 9. Bir 16 NOF	thplace (State or Foreign cunity) RTH CAROLINA
	and wo		Usual Residence of Dece 10a. State 10b.	County		10c. City	y, Town or Loc	ration					
	Many -f sho	ţō	MD P	RINCE	GEORGE'S			SVILLE					10d. fnside City Limits 1X Yes 2 □ No
	r 28a	Director	10e. Street and Number	KINOL	CLORGE B		DELI	10f. Zip Coo	le		10a C	itizen of What Co	
	death with the Maryland me 23a or 28a-f show [must be notified at	aiD	11844 ELLIN	IGTON 1	DRIVE			2070				J.S.A.	ountry?
S S	s 1 end 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 ie marked other than "naturel", or iteme 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral I	11. Marital Status 1 Never Married 2		12. Was Decedent Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:		4Y	/as Decedent Yes, specify 0		(Specify Yes or Nuerto Rican, etc.)		14. Race - Ame Black, Whit	te, etc.
9200-	ture		3 Widowed 4 D	ecedent's Ec								Specify:	BLACK
Ò	n "na Nedic	piet	(Specify onf)	y highest gra	de completed)		16a. Decede (Give k life. D	ent's Usual Oc rind of work do O NOT use re	cupation ne during most of	working	16b. l	Kind of Business	Industry
7	d with	Completed	Elementary/Secondary	(0-12)	College (1-4or 5 2+	+)	AUTO				P	RIVATE	
aud	al Hy d other	Bec	17. Father's Name (First, A	Middle, Last)					18. Mother's N	Name (First, Middle			
Ž	Ment Ment Mrkec	To	HENRY CAR	SON					L	ENA COW	AN		
Nar	12 sh h and 7 le m raum		19a. Informant's Name/Re				19b. Mailing	Address (Stre	et and Number or	Rural Route Numb	er, City	or Town, State, 2	Zip Code)
บ์	1 end Healtt em 27 ther t		GERALDINE C 20a. Method of Disposition		WIFE	20h BI	11844	ELLING	GTON DRIV	E BELTSV			
2	permit. Pages 1 en Department of Healt Important: If Item 2 eny Injury or other once.		1 ⊠ Burial 2 □ Crem	nation 3 🗌		Ce	ace of Disposi metery, crema RYLAND	atory or other i	olace)	Date 15/2005		ocation - City or	
	permit. F Departme Importan eny Injur		4 Donation 5 0			FIAI			dress of Facility				,MARYLAND
ă	Depa Depa Impo eny li		X.D.	Man	hall		74	74 LAN	DOVER ROA	AD LANDOV	ER.N	INS FUNE IARYLAND	RAL HOME 20785
				ase, or comp e. List only of	lications that caused one cause on each lin	the death. e.	. Do not enter	the mode of c	lying, such as card	liac or respiratory a	rrest,		Approximate Interval Between
	Physician /Medical	ĺ	tmmediate Cause (Final disease or condition resulting in death)	_	a Hyperten			Disease	9			4	Onset and Death
	Examiner				Due to (or as a	consequ	ence of):						
		je	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that interests are continued.)	i. ie	b. Due to (or as a	conseque	ence of):						
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Ś	e exe dan al urial-1	EX	resulting in death) Last	- 1	Due to (or as a	conseque	ence of):						
	ifficate be executed g physician and as the burial-fransit	edical		•	d								
<	eath certific attending p for use as	/Me	fF FEMALE:		22a If was automore	4							
	Ine law requires that the death cert tie hes been signed by the attending age 2 should be detached for use a	Physician/M	23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Petal o	death 3□E	ctopic pregnar Other (specify)	су			23d. Date of delin Month	very Day Year
	igned be deta	by P	Part If. Other significant co	onditions co	ntributing to death bu	t not result	ting in the und	erlying cause (jiven in Part f.	23e. Did to	bacco u	use contribute to	the cause of death?
	w require been sig				···					101		□No 3□Pro	34
	law r	ompleted								24a. Was		24b. Were aut	opsy findings available ompletion of cause of
		50									rmed? 2 \Begin{array}{c} No	prior to co death? 1 V Yes	+
	ertif	Be	25. Was case referred to m examiner?		1				26. Place of De	eath (Check only o		7,163	20,10
;	rat dir	ရှ	1 No 2 No 2 No 27. Manner of Death		lospital: 1 Inpatien 28a. Date of Injury			3 DOA		Home 5 ☐ Resid			M AT SCENE
	Attending r death. ector: After by the funer	Ion	1 Natural 5 ☐ F	ending nvestigation	(Month, Day	Year)	8b. Time of Injury	28c. Inj W	uryat ork? ⊒Yes 2.⊒No	28d. Describe h	iow infun	y occurred	
	r dea ector by the	Eca	3 ☐ Suicide 6 ☐ C	Could not be	28e. Place of Injur	v - At hom	e. farm. street			28f Location (S	'tmot o s	d Number of D	
	s afte	Certification:	4 Homicide		building, etc.	(Specify)	.,	. restory, omo	,	City or Tow	n, State,	d Number or Run)	ar Houte Number,
	Funer Funer Bly fill		29a. Certifier 1 Ce (Check only 2 YMa	rtifying Phy	sician: To the best of	my knowl	edge, death or	ccurred at the	time, date and place	ce, and due to the o	ause(s)	and manner as s	stated.
	within 2 To the	Medical	29b. Signature and title of c		nar: On the basis of e and manner state	ed.	11 2110/01 111463						
ŀ	8 7 8		230. Signature and title of C		200				.C.M.E	ż	9d. Date SEP	e signed (Month. $2T.9,20$)	Day, Year)
		-	Name and address of a	du-	10llel	100	0-1-5						
_			Name and address of po	TAL I	A-VOLAK	1111 1	PENN ST	REET, B	ALTIMORE,	MARYLAND	212	01	
	Stat		31. Date filed (Month, Day,	Year)	22. Registrar	s Signatur							
	Registra	r	SEP 1	3 2005	Blave	K	Loss						

State of Maryland / Department of Health and Mental Hygiepe For Stata Registrar 30229 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day MARJORIE L. CLARKE August 26 2005 3:42 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 M F Yrs. Director 251,28,3965 82 July 6, 1923 South Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be nutified an once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 902 Balmoral Drive 20903 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Marvland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify: White 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Secretary National 4-H Council l Year 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) C. Grover Little Jessie Boardman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antonia C. Selinsky/Daughter 117 Buttercup Drive, Cranberry Township, PA 16066 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State d Fort Lincoln Crematory 9/1/2005 Brentwood, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Ave, Silver Spring, Non MD 20904 23a. Part1. Enter the set, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear shilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Septic Shock disease or condition resulting in death) 48 Hours /Medical Due to (or as a consequence of): Examiner 2 Weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Acute Leukemia Due to (or as a consequence of) Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has b page 2 sl autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 🔯 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) After the funeral 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Hospitei or Attending 1 X Natural 5 Pending М 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours e 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) the 29b. Signature and title of certifie 29c. License number 2 2 29d. Date signed (Month, Day, Year) D-29675 August 29, 2005 30. Name and odress of person who completed cause of death (Item 23a) (Type, Print) 12 Ralph Boccia, M.D., 6420 Rockledge Drive, Bethesda, Maryland 20817 31. Date filed (Month, Day, Year) 32. Registrar's Signature 0 Registrar

			1- State of Maryland / Dep	artment of Health and Nartificate of Death	Mental Hygier Reg. Í	2005 30230
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medio		HYANG RHIM CHAH			29 2005 8:08 P M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			1984 Lancashire Drive	Rockville		Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 S F 61 Yrs.) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
Н	Director	ļ	504.74.5695 1		Nov.12, 1	
	yland yland		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Mar.	ţċ	Maryland Montgomery Rockvill	Le		1 X Yes 2 ☐ No
	th the or 28,	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	23a (23a usit b	al	1984 Lancashire Drive	20854	1	U.S.A.
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. I hatural, or items 23a or 28a-f show event, the Madical Exerciner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Asian
5-0	72 ho	eted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv	edent's Usual Occupation s kind of work done during most of work	16b.	Kind of Business/Industry
21	within ene. than "	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
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Maryland		Be	17. Father's Name (First, Middle, Last) Pyung Ok Choi		e (First, Middle, Maid	en Sumame)
Ž	shoutd be and Mental Is marked o	은	• 0	Jungmy o		vor Town State 7's Code
Ma	OI (0 - 6			Lancashire Drive,		
ē,	ges 1 and 2 t of Health If item 27 or other tra		20a. Method of Disposition 20b. Place of Disp			Location - City or Town, State
Baltimore,	Pages nent of int: If it		1 🗷 Burial 2 Cremation 3 Removal from State 14 Donation 5 Other (Specify) Norbeck 1		1/2005 01n	ey, Maryland
alti	nit. artn orts injt			2. Name and Address of Facility LNES-RINALDI FUNER		
<u>m</u>	Dep Imp any	(f)	Nancy A. Versenly 1	1800 New Hamsphire	AL HOME, I Ave, Silv	er Spring, MD 20904
Ц			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition southing or condition	extension		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence):			
ķ.		i i	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of the control of the	15 pepsia		
	uted	Examine	Cause (Disease or injury	La de Dada		
Ċ,	be executed sician and burial-transit	Еха	that inflated events c. Due to (or as a consequence of):	rolugar gra	<u> </u>	
68760,	icate be executed physician and s the burial-transit	edical	d			
		Med	IF FEMALE:	110-21170-211		
O. Box	law requires that the death certifulas been signed by the attending I	Physician/M	23b. Was decedent pregnant in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
م َ	that ned b	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
rds	quires an sign				1 ☐ Yes	2XNo 3 ☐ Probably 4 ☐ Unknown
Vital Records,	law requir as been si 2 should	Completed			24a. Was an	24b. Were autopsy findings available
Ä	9 - 9	E O			autopsy performed?	prior to completion of cause of death? In the second seco
ita	ysician: This contilicate	ВеС	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	103 20110
of V	Physician: this certific ral director.	70	1 ☐ Yes 2 DNo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Other: 4 Nursing Ho	me 5 Residence	6 ☐ Other (Specify)
		on:	27. Manner of Death 1 ★Natural 5 Pending 28a. Date of Injury 28b. Time of Injury Injury 1 (Month, Day Year)	f 28c. Injury at Work?	28d. Describe how inj	ury occurred
Sic	tend leath tor: the	icat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No		
Division	l or Atten after deat Director: I in by the	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	- C	29a. Certifier Certifying Physician: To the best of my knowledge, deal	h occurred at the time, date and place	and due to the cause/	s) and manner as stated
	the Ho hin 24 h the Fu npletely	edica	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurr	ed at the time, date ar	nd place, and due to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifie	29c. License number		ate signed (Month, Day, Year)
)			Il) In Soul &	D/3/2	1 Au	Eless bug, lyd
	2		30. Name a address of person who completed cause death (Item 23a) (Type,	Print)	. 0.	
			31. Date filed (Month, Day, Year) 32. Registrar's Signature	Jady / TOVEC	t, Bail	hersburg, Md
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	raction		20879
	3,011		A CARLOS OF PAR			

			1 - For Amend Item Registrar	old per ver	b., co-ce	rtificate of De	ath	Reg.	2005	30231
п	Physicia	an	1. Decedent's Name (First, Middle, Last,)			2	2. Date of Death Month	Day Year	3. Time of Death
4	/Medic		MARY GERTRUDE					SEPT. 7	2005	11:15 AM
*	Examin	ęr	4a. Facility Name (If not institution, give			4b. City, Town, or Loca	ation of Death		4c. County of Deat	th
			12713 BAR OAK D		n yrs. last birthday)	WALDORF	Jnder 24 Hrs. g	. Date of Birth	CHAR	
г	Funeral Director		-	Эм 2)ДГ 8(Ven		ours Min.	(Month, Day, Ye		hplace (State or Foreign
	Ð		Usual Residence of Decedent					AN.5,19	125 MA	RYLAND
	anylan show	_	10a. State 10b. County		Dc. City, Town or Lo	ocation				10d. Inside City Limits
	Be-f s	Director	MARYLAND CHARL	ES	WALDO	RF				1 ☐ Yes 2 No
	with th	Dire	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
	s 23e	eral	12713 BAR OAK D	RIVE 12. Was Decedent Eve	w in 11 C 12	20601	-i- O-i-i-2 (Ci	4. VN-	U.S.A.	des to the
	Items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	or in 0.5.	Was Decedent of Hispan If Yes, specify Cuban, Mo	exican, Puerto Ri	can, etc.)	14. Race - Ame Black, Whit	
936	ars af	by F	3 € Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2/☐No Sp	pecify:		Specify:	BLACK
5-0036	be filed within 72 hours after death with the Maryland the Whyliene. A the Wyliene and other then "netural; or terms 23a or 28e-f show other then "netural; or terms 23a or 28e-f show avent, the Medical Exam ner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	ication	16a. Dece	dent's Usual Occupation kind of work done during	a most of working	16b	. Kind of Business/	Industry
2121	- E 30	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	g most of working			
CA	filed w Hygier Ither th	Cor	10		HOM	EMAKER			OWN HO	ME
and	ntal H ad ot	Be	17. Father's Name (First, Middle, Last)			_		First, Middle, Maid	len Sumame)	
Maryland	2 should be filled within and Mental Hygiene. Is marked other then eumetic event, the Ma	²	DANIEL COLE 19a. Informant's Name/Relationship (T)	vne Print)	19h Maili	ng Address (Street and N	ESLIE I		hy or Tourn State	Zin Codo)
Ma	nd 2 salth an 27 ls i		JOYCE WINTERS-D		1	3 BAR OAK			•	
ē,	Heg Heg the		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	DIX • / V		Location - City or	
Baltimore,	0 0 = =		Burial 2 ☐ Cremation 3 ☐ F			matory or other place)	1			V6232
ij	- 돈은 근		21. Signature of Funeral Service Licens	TV7		MORIAL GD		2-05 LW.	ALDORE,	MARYLAND
ä	Depa Impo any ii		Willed	1	1,5	RAYMOND FI	UNERAL	SERVIC	E, P.A.	
	8		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the	death. Do not en	EA PLATA er the mode of dying, su	MARYL A ch as cardiac or	espiratory affest,	546	Approximate Interval Between
	Pnysician _i		Immediate Cause (Final disease or condition	COL	0 P C	ancel	2			Onset and Death
	/Medical		resulting in death)	Due to (or as a co	onsequence of):					
77	Examiner	_	Sequentially list conditions,	b						
	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):					
	xecut and at-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as a co	onsequence of);					
68760,	icate be executed physician and s the burial-transit			d						
		edical								-
Вох	eath certil attending for use a	M/W	230. Was decedent pregnant	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐		Ectopic pregnancy			23d. Date of deli	ivery
.00	The law requires that the death certil te has been signed by the atlending vage 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time		Other (specify)			Month	Day Year
P.0	that the de led by the detached	Phy	9 Unknown							
S,	res tha signed be det	by	Part II. Other significant conditions con	tributing to death but he	ot resulting in the u	nderlying cause given in	Part I.	23e. Dig tobacc	_	the cause of death?
orc	w require been sign	eted						_	2 140 3 1	JUNE OF THE PROPERTY OF THE PR
of Vital Records,	e law has t	-						24a. Was an	24b. Were au	topsy findings available
al	9 4 9	E C						autopsy	prior to d	completion of cause of
Vit.		Completed							prior to d	completion of cause of
		Be	25. Was case referred to medical examiner?	Hospital:		Other	Place of Death (6	autopsy performed 1 Yes 24	prior to death? No 1 ☐ Yes	eampletion of cause of
	Physicien: this certifica ral director, p	To Be	eyaminer?	28a. Date of Injury	2 ER/Outpatier	nt 3 DOA Other: 4	☐ Nursing Home	autopsy performed 1 Yes 24	? prior to death? No 1 □ Yes	eampletion of cause of
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra MEND#1perMD9/1/05, BMW, McCo Reg. NZ 005 Certificate of Death 1. Decedent's Name (First, Middle, Last) ISRAEL 2. Date of Death CASTILLO-MARTINEZ **Physician** 00:09AM AUG 200S /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner MARYLAN BALTIMORE IVERSI OF CENTE MEDICA If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8/01/19/1986 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2 □ F 19 Yrs Director none Mexico Usual Residence of Decedent the Maryland wiven, it from £7 is marked other than "neturel", or liems 23a or 28e-f show injury or other treumatic event, the Modical Externinat must be notified at 8. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Prince George's Brandywine Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? ¥ 12108 Crestwood Turn 20613 Mexico death Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after inent of Health and Mentai Hygiene. Int: If item 27 is marked other than "neturel", or Itel Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ₩ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Ves 2 □ No Specify: Mexican White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Drywall Mechanic Construction 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Tomas Castillo Andrade Maria Del Socorro Martinez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresita Castillo/Cousin 12108 Crestwood Turn Brandywine, Md 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If Municipal Cemeterio 9/7/05 San Luis Potosi, 21. Signature of F meral Service License PHILIP D. RINALDI FUNERAL SERVICE, P. A any 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death **Physician** /Medical resulting in death) Due to (or as a consequence of): **Examiner** MO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner signed by the attending physician and deelached for use as the buriat-transit the death certificate be executed MI that initiated events resulting in death) Last to (or as a consequence of). Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq 1 ☐ Yes No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 🗌 No 2 □ No Hospital or Attending Physicien: 24 hours after death. Funerel Director: After this certifice director, Be 25. Was case referred to medical 26. Place of Death (Ch. ck only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 1 🗌 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the within 2 29b. Signature and title of co 29c. License number 29d. Date signed (Month, Day, Year) MDP 17783 Pediatric Critical GreFellon 3 30. Name and addregs/of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Mohamed 62
31. Date filed (Month, Day, Year)

0

SEP

egistrar's Signature

32

South Greenest Rm NSEBBaltimore, MD 21201

			for State Registrar	State of Maryl		artment of H <i>rtificate of l</i>			ene 005	30233
	Diam'r.		1. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month	n Day Year	3. Time of Death
	Physici /Medio		Angela B. Cobos						29, 2005	3:13 A M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	Ü	4c. County of Dea	ath
			Washington Advention S. Social Security Number 6. S			Takoma If Under 1 Year	Park If Under 24 Hrs.	0.5(5:	Montgome	
	Funeral Director		1	□M 252F	yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,		rthplace (State or Foreign ountry)
			577-84-0486 Usuel Residence of Decedent	68				June 4,	1937 Cos	sta Rica
	rylan thow	_	10a. State 10b. County	10c.	. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f s	Director	Maryland Montgor	nery	Silv	er Spring	<u> </u>			1 ☐ Yes 2 ☑ No
	vith th	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	s 23g	erai	9006 Manchester Ro	oad #28 12. Was Decedent Ever i	n II S 12	Was Decedent of H		acity Vas or No.	Costa Ric	
40	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces?	10.3.	Was Decedent of Hi If Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)	Black, Whi	
036	hours after death with the Maryland turel', or Items 23a or 28s-f show at Examinst must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1√2 Yes 2□ No	Specify:	a Rican	Specify:	White
Maryland 21215-0036	thin 72 hours after death with the Marylan e. an "neturel", or Items 23s or 28s-f show Medical Examinet must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	dent's Usual Occupa	ation	1	6b. Kind of Business	
7	within ene. than "	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	()	9		
2	e filed withle Il Hygiene. other than vent, the M		17. Father's Name (First, Middle, Last)		House	keeper	40 Mathada Nasa	a (Prima a Beindadha Bu	Domestic	
anc	I be fi	Be					18. Mother's Name		_	
Ž	hould d Me mark matic	2	Eligio Barboza 19a. Informant's Name/Relationship (7	US-	19h Maili	ng Address (Street :	Auroi		lez City or Town, State,	Zin Code)
<u>≅</u>	nd 2 s lth ar 27 is r trau		Edgar O. Cobos Jua			200 5049	5 9802		•	
ē,	f Healitem	. 18	20a. Method of Disposition	20	b. Place of Dispo	Mancheste sition (Name of matory or other place			er Spring,	Town, State
Ë	Page Int: #		1 ☐ Burial 2 🛣 Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		etropoli	tan Crematory	1	2005	1	****
Baltimore,	permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If item 27 Is marked other t any injury go other traumatic svent, III once.		21. Signature of Funeral Service Licen	See O	2	2. Name and Addres	ss of Facility		lexandria,	,virginia
<u> </u>	88 = 8		Michen	Cole	50	U Univers	ity Blvd.	Silver	Home, Inc. Spring, MD	20901
			23a. Part1. Enter the disease, or con part shock, or heart failure. List only	plications that caused the cone cause on each line.	leath. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Sudden Card	liac Dea	th S/PCar	diopulmor	narv Arre	est	Onset and Death
	/Medical Examiner		resulting in dealtry	Due to (or as a con			•	,		
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Ventricular Due to (or as a con	r Fibril sequence of):	lation Re	current			
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	c Ischemic Ca	ardiomyn	athw				
o,	exec an an	Еха	resulting in death) Last	Due to (or as a con	sequence of):	acity				
68760,	The law requires that the death certificate be executed tile has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical	(d Coronary An	ctery Di	sease S/P	By Pass (Graft		
	ertific ling p	Med	IF FEMALE:	20-14						
Вох	eath cert attending for use a	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	etal death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
o.	that the de led by the a detached t	Physician/M	1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at time 9☐ Unknown	orueaur 5L	Other (specify)				
<u>α</u>	that ned by deta		Part II. Other significant conditions co	ontributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	o the cause of death?
Vital Records,	quires n signi	ed by	Respiratory Failu	ıre				1 🗀 Yes	s 2 No 3 P	robably M Unknown
000	aw require s been si 2 should t	Completed	Acute Hypoxic Enc	enhalonathy	Probabl	v Due To		24a. Was an		utopsy findings available
Re	The lavate has	mo	Cardiopulmonary A		LIVIUDI	<i>y</i> 1046 10		autopsy perform 1 Yes 2	ed? death?	completion of cause of
ital		Be C	25. Was case referred to medical examiner?	TIEST			26. Place of Deat	(Check only one		
of <	Physic this ce al dire	To	1 ☐ Yes 2 🗷 No		2 ER/Outpatier	nt 3 DOA Othe	4 Ituising no		nce 6 Other (Spe	icity)
n c	ing F	inol	27. Manner of Death 1 √Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time o	Worl	</td <td>28d. Describe how</td> <td>w injury occurred</td> <td></td>	28d. Describe how	w injury occurred	
isic	ttendi death. stor: A / the fu	icat	2 Accident investigation 3 Suicide 6 Could not be		At home farm et		Yes 2□No	28f Location (Str	eet and Number or R	ural Pouto Number
Division	of or Attend after death Director:	Certification:	4 Homicide determined	building, etc. (Sp	ecify)	eet, ractory, onice		City or Town,	State)	arar riodig reamber,
	s Hospitel of 24 hours at e Funerel Dietely filled in		29a. Certifier 1 X Certifying Ph	ysicien: To the best of my	knowledge, deat	h occurred at the tim	ne, date and place,	and due to the car	use(s) and manner as	s stated.
	To the Hospitel or At within 24 hours after of To the Funerel Directompletely filled in by	Medicai	one)	iner: On the basis of exan and manner stated.	nination and/or in	vestigation, in my or	oinion, death occurr	ed at the time, da	te and place, and due	e to the cause(s)
	To the I	Σ	29b. Signature and title of certifier			29c. License	e number	29	d. Date signed (Mont	th, Day, Year)
)	5		1 Cm	w		D	56115	Au	gust 31, 2	2005
	5		30. Name and/address of person who o							
		•	Gorgonia V. Ferre	r, M.D. 76	10 Carre	oll Avenu	e Takom	a Park,	Maryland	20912
	Sta Registr			32. Aegistrar's S	10. 19	Marketon.				¥
				- 7						

			1 - State Registrar	State of M		d / Depa	artment o rtificate	of Hea	alth and	-	/giene	005	30234
			1. Decedent's Name (First, Middle, Last)						2. Date of D	eath		3. Time of Death
	Physici /Media		CARL LESTER CALLI	S						SEPTEM	IBER 7,	2005	2:25 AM
1	Examir		4a. Facility Name (If not institution, give				4b. City, To	wn, or Lo	cation of Deat	h	4c. Cou	nty of Death	
			GARRETT COUNTY MET				OAKI		II-4-04II			ARRET'	
	Funeral Director		5. Social Security Number 6. Se 220–10–0907	'	ge (in yrs. id 84 ————	ast birthday) Yrs.	If Under 1 \ Months D		Under 24 Hrs Hours Min.		th ay, Year) 1921	9. Birth	place (State or Foreign htry) YLAND
	/land		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	Many Many	to	MD GARRE'	ГТ		OAKLAN	ND						1 ☐ Yes 2 🙀 No
	th the	Funeral Director	10e. Street and Number				10f. Zip Co	ode			10g. Citizen	of What Cou	ntry?
	23a ust b	rain	3855 MARYLAND HIGH	HWAY			2	21550			USA		
	ar dez	Tue	11. Marital Status	Was Decedent Armed Forces'	?	3. 13.	Was Decedent f Yes, specify	t of Hispa Cuban, N	ınic Origin? (S Mexican, Puer	pecify Yes or Note Rican, etc.)	o- 14. F	ace - Americ	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mentat Hygiene. If Item 27 is merked othar than "natural", or Items 23a or 28a-f show or othar traumatic svant, the Madical Examinatry ust be multified at	ē	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∰ Yes 2 □ If Yes , Give Year or Dates:	THITT		1□Yes 2ሺ	No S	Specify:		Spe		
5-0	72 h	Completed	15. Decedent's Edu (Specify only highest grad			16a. Deced	ient's Usual O	ccupation	n na most of wo	rkina	16b. Kind of	Business/In	dustry
121	vithin ne. han	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)				ng most of wo				
2	filed v Hygie othar t		17. Father's Name (First, Middle, Last)	12			CABLE S			ne (First, Middle			COMPANY
and	d be f	Be c	DELPHUS ELLSWORTH	1 CALLIS				10		IE OLLII		ame)	
7	2 should be f and Mental Is marked of aumatic sva	ဋ	19a. Informant's Name/Relationship (T)		Ŧ	19b. Mailin	ng Address (St	treet and		ral Route Numb		n State Zin	Code
	and 2 sealth ar		NINA B. CALLIS -						HIGHWA		LAND, M		
ē,	s 1 and f Health Itam 27 othar tr		20a. Method of Disposition		0.00	ace of Dispo	sition (Name o	of		Date	20c. Locatio		
Ę	Pages nent of int: If It		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify))		VALLE		4. 9/1	0/05	OAKLAN	ID. MA	RYI.AND
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	ee <u>L</u>	J		. Name and A	ddress of			BOX 24		
8	8 9 E 5 8		Coluit My No	wet	M001	.67 D	URST FU	JNER/	AL HOME	- OAKL	AND, MI	2155	0
	Physician /Medical Examiner	L	23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. HEAT Due to (or as	ine. D TRAU s a consequ	IMA - I				c or respiratory a	ırrest,		Approximate Interval Between Onset and Death 12 HOURS
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as Due to (or as									
.O. Box	at the death certific by the attending p tached for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pregn Other (specif					Date of delive	ory Day Year
rds, P	quires tha n signed l uld be det	ρ	Part II. Other significent conditions con SEVERE CONGESTIV				iderlying causi	e given in	Part I.				e cause of death?
of Vital Records,	The law requir sate has been si page 2 should	Completed	CARDIAC EJECTION	FRACTION	N LESS	5 THAN	20 %				psy ormed?	b. Were autoperior to condeath?	psy findings available inpletion of cause of
ita		Be C	25. Was case referred to medical examiner?					26	Place of Dea	th (Check only o		1 103	20 100
<u></u>	Physiclan: this certific ral director,	2	1X Yes 2 No	lospital: 1 🔀 Inpatio	ent 2 🗆 E	R/Outpatien	3□ DOA	Other:	I ☐ Nursing H	ome 5 Resi	dence 6 0	ther (Specify)
ion o	Attanding Pt r death. ector: After th by the funeral		27. Manner of Death 1 □ Natural 5 □ Pending 2 ☒ Accident investigation	28a. Date of Inju (Month, Da 9/6/05	iry Year)	28b. Time of Injury		Injury at Work? 1 Yes	2 X No	28d. Describe PASSENG IN COLL			E INVOLVED
Division	in Diric	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injusting, et WITHIN	tc. (Specify)				IAY	28f. Location (City or Tot RT. 135	vn, State)		ARK, MD
	To the Hospital or Al within 24 hours after of To tha Funaral Direc completely filled in by	edical (29a. Certifier (Check only one) 1 ☐ Certifying Physical Exemition (Check only one)	sicien: To the best ner: On the basis o and manner st	of examination	rledge, death on and/or inv	occurred at the	ne time, d my opinio	ate and place n, death occu	and due to the	cause(s) and r	nanner as st	ated
	To the within To the Comp	Me	29b. Signature and title of certifier	illi		<i>J</i> -	29c. Lic	cense nu			29d. Date sign	ed (Month, I	Day, Year)
			1/Leils.	// Cu	411	(May)	100	100	5180	/	SEPTEM	BER 8,	2005
			30. Name and address of person who co KEN BUCZYNSKI, M				Print) FOURTH			OAKLAND,	MD 21	550	
	Sta Registr		31. Date filed (Month, Day, Year)		rar's Signatu	ire	FOURTH	. DIV	<u> 1</u>	OUNTWIND.	_ FID <u>21</u>	<u>))((</u>	

			. 101	partment of Health and Mer e <i>rtificate of Death</i>	ntal Hygiene	005 3UZ33
	Dhusisi		1. Decedent's Name (First, Middle, Last)		Date of Death Month Dar	y Year 3. Time of Death
	Physici /Medic	al	Vau O. Coleman	4b. City, Town, or Location of Death	eptember	1, 2005 2:00 M
	Examin	er	4a. Facility Name (If not institution, give street and number) St. Catherine's Nursing Center	Emmitsburg		Frederick
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min.	Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
	Director		217-05-6433	Ja	an 29, 19	17 Maryland
	arylanc show	<u>.</u>	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits 1 XYes 2 □ No
	the Ma	Director	Maryland Frederick Emmit 10e. Street and Number	sburg 101. Zip Code	10g. Cit	izen of What Country?
	h with		331 S. Seton Ave.	21727	US	·
	tems ?	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 1. Armed Forces?	3. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric		14. Race - American Indian, Black, White, etc.
336	hours after death with the Maryland tural", or Items 23a or 28a-1 ehow al Examiner must be multiped at	by	1 Never Married 2 Married 1 2 Yes 2 No 1941 Yes, Give 1941 Yes ro Dates:	1 ☐ Yes 2 XNo Specify:		Specify: White
2-0	72 hours "natural", ulcal Exp	eted	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of working	16b. K	ind of Business/Industry
21215-0036	S - 3	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ahouseman	S	un Oil Company
	Hyg Hyg the	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (F	irst, Middle, Maiden	Sumame)
Maryland		To	Oscar Coleman		en Callah	
Mai	d 2 s thar 7 ts trau			illing Address (Street and Number or Rural Ro 5 Ruby Dr. Westminst		21158
ore,	s 1 a f Hei item othe		20a Method of Disposition 20b. Place of Dis	position (Name of Date rematory or other place)		ocation - City or Town, State
Baltimore,	Pag nent ant: f		`4 Donation 5 Other (Specify) Druid R	idge Cemetery 9/6/20		esville, Maryland
Bal	permit. Departr Importe any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Pritts 412 Washington Rd. We	s Funeral	Home & Chapel, PA
			23a. Part1. Enter the disease, or complications that it used the death. Do not shock, or heart failure. List only one cause of Facilities.	en er the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	& Dementia		Onset and Death 2 years
	Examiner		ue it (or as a consequence of):	tu Crediovascu	la Au	in 10 years
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	· · · · · · · · · · · · · · · · · · ·	10	30
	cate be executed physician and s the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last c. Que to Q = a consequence of):	Va-		at years
68760,	te be e ysiciar ne buria	dicai E	d			V
_			IF FEMALE:			
Вох	death certific e attending p ed for use as	Physician/M		3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
P.O.	0 0 0	hysi	9 Unknown			
Ś	The law requires that the ate has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown
Record	w requ been should	ietec			24a. Was an	24b. Were autopsy findings available
Re	The lav	Completed			autopsy performed? 1 ☐ Yes 2 1 No	prior to completion of cause of death?
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death (C		
of	hys his	J; To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28d	5 Residence Describe how injure	
ion	ending Fath. or: After he funer	atio	1 Matural 5 Pending (Month, Day Year) Injur 2 Accident investigation	M 1 Yes 2 No		
Division	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, building, etc. (Specify)	street, factory, office 28f.	Location (Street an City or Town, State	d Number or Rural Route Number,)
	spital nours in noral y filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de			
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral completely filled in the funeral completel	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.			
)	5 € 5 P	4	29b. Signature and title of certifier	29c. License number 05	29d. Da	le signed (Month, Day, Year)
	MIL		30. Name and address of person who completed cause of death (Item 23a) (Typ. Dr. Alan Carroll 310 S. Setm Ave		10 21	727
	Sta		31. Date fited (Month, Day, Year) 32. Registrar's Signature			
	Registi	rar	SEP 0 2 2005 Street &	Soul,		

DHMH 17 Rev 1/2001

ORIGINAL

		•		eartment of Health and Mertificate of Death		iene 2005	30236
Ħ	Dhypigir		Decedent's Name (First, Middle, Last)		2. Date of Deat Month	3	3. Time of Death
	Physicia /Medic	al,	Thomas E. Coates	14.03.7	August	27 2005	5 0605 ^M
	Examin	er	4a. Facility Name (If not institution, give street and number) Snow Hill Nursing Home	4b. City, Town, or Location of Death Snow Hill		4c. County of De	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		8. Date of Birth (Month, Day,		irthplace (State or Foreign Country)
	Director	}	214-20-5836 1 TM 2 F 78 Yrs. Usual Residence of Decedent	Marine Sayo Marine	July 14		MĎ
	laryland show		10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	e Mar Ba-f st	Director	MD Worcester Berlin				1 X Yes 2 ☐ No
	with the	Dire	318 West Street	10f. Zip Code	10	0g. Citizen of What 0	-
	death ms 23	Funerai		21811 Was Decedent of Hispanic Origin? (Spell Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Arr	erican Indian,
2	should be filed within 72 hours after death with the Maryland not Mently Hygiene. In marked other than "natural", or tems 23a or 28a-f show umatic event, the Medical Examinational to notified at	by Fur	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No INO VY	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	Rican, etc.)	Specify: Bl	
Ś	hours stural,	ed b	3 Notidowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Dec	edent's Usual Occupation		16b. Kind of Busines	
2	hin 72 9. Bin "na Medis	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of worki DO NOT use retired)	ng	TOD. TURIS OF DESITIOS	3 mad stry
V	led will ygien her tha	Con	10th	Manager		Hotel	
2	d be fil) Be	17. Father's Name (First, Middle, Last) unknown	18. Mother's Name	unknowr		
		인		ing Address (Street and Number or Rura			Zip Code)
ž.	1 and 2. Health are om 27 is other trau			Goodluck Rd., Sea			
2	ages 1 nt of H : If iten or oth		1 🗆 Buria: 2 💽 Cremation 3 🗀 Hemoval from State	amatory or other place)		20c. Location - City o	
	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra			of Delmarva 8/29/	2005	Delmar, D	E
ă	Dep Imp any any) / 100	Lewis N. Watson Fur 1618 West Rd Sal	neral Ho	me MD_21801	
			23a. Petrl. Enter the disease, or complications that caused the death. Do not esshock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
ı	Physician /Medical		disease or condition resulting in death)				2-mth
	Examiner		Due to (or as a consequence of):				
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			-	
_	xecute and II-trans	Examiner	Cause (Disease or injury that initiated events c. Pue to (or as a consequence of):				
Š	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical E	d				
0	ntificat ing ph) e as th	O I	IF FEMALE:				
YOU	leath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	□Ectopic pregnancy		23d. Date of de Month	Day Year
į	that the de ed by the detached	nysic	1 Yes 2 No 9 Unknown	Other (specify)			
, L	uires that signed b	by P	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			to the cause of death?
2	v requir been si should				1 XYe:	s 2 No 3 F	robably 4 Unknown
טע	sician: The law certificate has b irector, page 2 s	Completed			24a. Was an autopsy perform	/ prior to	utopsy findings available completion of cause of
2	an: Ti tificate tor, pa	a)	25. Was case referred to medical	26. Place of Death	1 ☐ Yes 2	⊠No 1 □ Ye	s 2□ No
>	Physici this cer al direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Other		nce 6 □Other (Spe	ecify)
=	Jing P	:lon:	27. Manner of Death 1 Natural 5 ☐ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	w injury occurred	
	Attending Physician: The or death. Sector: After this certificate his by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s		28f. Location (Str.	eet and Number or F	Tural Route Number,
5	rs afte rs afte ral Dir	Cert	4 ☐ Homicide determined building, etc. (Specify)		City or Town,	. State)	
	To the Hospital or Attending Physician: whith 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director; t	edicai	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deal can be described by the control of	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	and due to the car ed at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the To the comp.	M	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Mon	
	8		20. Name and address of passes who appropriated cover of dark (Name 20.)	2 3445C		8/29/0	5
	7		30. Name and address of person who completed cause of death (Item 23a) (Type 160 TY - Market St., 100 Comp	2 000	851		
: 3	Sta Registr	_	31. Date filed (Month, Day, Year) AUG 3 1 2005 32. Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene 0 0 5

30237 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 28,2005 Yeer **Physician** 2:50AM ROSE Ν. /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner Charles Waldorf Health Care Center Waldorf If Under 24 Hrs. Birthplece (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 09/21/1910 5. Social Security Number 7. Age (In yrs. last birthdey) Funeral Deys Months Hours 1□ M 2 KF 94 578-46-3067 Macon, GA Director Usuel Residence of Decedent permit. Pegas 1 and 2 should be filed within 72 hours effer death with the Meryland Department of Health and Mentel Hygiene. Important: If tem 27 is marked other than "natural" or harm not any Injury or other trainment. 10b. County 10c. City, Town or Locetion 10d. Inside City Limits 10a. Stete MD 1 Tyes 2 No Charles Waldorf Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 2005 St. Thomas Drive 20602 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Stetus 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Merried 2 Married 1 ☐ Yes 2 € No Specify: Specify: White δ 3 ☑ Widowed 4 ☐ Divorced Year or Dates Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Housewife Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be John F. Kent Mattie Herndon 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Helen J. Piatt/daughter 5108 Oakland Way, Camp Springs, MD 20746 20b. Place of Disposition (Name of cometery, cremetory or other place)
Cedar Hill Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify) 9/1/2005 Suitland, MD 22. Name and Address of Fecility Cedar Hill Funeral Home, Inc. 21. Signature of Funeral Service Ligensee Hedgman 4111 Pennsylvania Ave. Suitland, MD 20746 23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final diseese or condition resulting in death) /Medical Examiner Physiclan/Medical Examiner this certificate has been signed by the ettending physician end al director, page 2 should be deteched for use es the buriel-trensit law requires thet the death certificete be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 Yes 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 TYUS 21XN0 To the Hospital or Attanding Physician: within 24 hours efter death. To the Funeral Director: After this nadding Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 3□ DOA 1 Inpatient 2 ER/Outpatient filled in by the funeral 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Date of Injury (Month, Day Year) 5 Pending 1 Natural
2 Accident 1 Yes 2 No investigation 6 Coutd not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death 29a. Certifier Medical completely Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifiel 29c. License numbe leted cause of death (Item 23e) (Type, Print) 30. Name end address of person who cor AUG 3 1 2005

DHMH 16 Rev 6/95

State Registrar

31. Dete fited

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie pe 0 5 30238 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death August 26, 2005 **Physician Edith Jean Cavey** 04:46 PM /Medical 4c. County of Death Allegany 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frostburg Frostburg Village Nursing Home If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 1 F Months Days Hours 20-Jan-1920 220-03-7799 85 Yrs. Director Usuel Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.
other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County ? Is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Madical Examiner is ust by notified at Maryland Frostburg Allegany 1 ¥Yes 2 □ No Director 10e. Street and Number 128 Walnut Street 10f. Zip Code 10g. Citizen of What Country? 21532-U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specif White 1 ☐ Yes 2 🖬 No Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Staff Textile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth any liqury or other traumatic event <u>ones</u>. Be Marcellus R. Llewellyn Anna Cutter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edith J. Cavey Self Frostburg Maryland 21532 20b. Place of Disposition (Name of cemetery, crematory or other plac Frostburg Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 29-Aug-2005 Frostburg Maryland ¹ 4 □ Donation 5 □ Other (Specify) Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 21. Signature of Funeral Service Licenses 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final lymphocyti **Physician** Chroni disease or condition resulting in death) years /Medical Due to (or as a consequence of): Examiner Sequentially ist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Advunced certificate has been 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 2 No 2**X** No 1 Yes or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 X No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours at To the Funeral Di Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Or box Yorks

Registrar
DHMH 17 Rev 1/2001

State

workers

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registar's Signature

SHIN

AUG 3 0 2005

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48 Tam Terrace Frostburg MD 21532

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	Physici	an	Decedent's Name	e (rirst, Midde	e, Last)						,, 20,	0,5	OH	2. Date of Month	Death	ay	Year	3. Time of 0	Death
	/Medio	al	4a. Facility Name (If		AVID n, give stre		LAN um <i>ber)</i>	CRA	TSENI	1	y, Town, or	Location	n of Death	Septe		05, c. County	2005 of Death		Р "
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2	Funeral		5. Social Security No	umber	6. Sex	2 🗆 F		(in yrs. last			ler 1 Year		er 24 Hrs.	8. Date of (Month,	Birth Day, Year	r)	9. Birth	place (State or intry)	
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	nyland how		10a. State	10b. County				10c. City, T	own or Lo	cation								10d. Inside City	•
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21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Itam 27 is marked other than "natural", or itams 23s or 28e-f show other traumatic avent, the Medical Examiner must be notified at	b	1 Never Marrio			Armed For 1 Types If Yes, Given or D	2 □ No ive		i	_	ecify Cuba 2 ∏ No	n, Mexic <i>Sp</i> ecif		Hican, etc.)		Specify	ck, White v: WI	, etc. HITE	
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Baltimore,	permit. Pages Department of Important: if it any injury or o		21. Signature of Fu	neral Service	Licensee	nber	10	M0009	22	Name HAM	and Addres BERS I	s of Fac	ility RAL H	OME &	CREM	ATOR	IUM.H	P.A.	
			23a. Part1. Enter the shock, or hear	ne disease, or	r complicat	tions that of	caused the	ne death. (<u>LE, r</u>	YID. 2	Approximate Interval Between	
>	Physician /Medical		Immediate Cause (disease or condition resulting in death)	Final	•	Drow	ning		ice of):									Onset and De	eath
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9		Med	IF FEMALE:		1														
.O. Box	that the death certitic ed by the attending p detached for use as	Physician/Me	23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	23c.	1 Live I	birth 2 nant at ti	pregnancy Fetal de	ath 3	Ectopic Other	pregnancy (specify)				-	23d. Dat Mor	te of deliv		ear
٥		þ	Part II. Other signifi	icant condition	ons contrib	outing to d	death but	not resultir	ng in the u	nderlying	cause give	en in Pan	t I.			_		he cause of de	
Vital Records,	The faw requires ite has been sign bage 2 should be	Completed												-	Yes 2			oably 4 Dun	
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ta		a	25. Was case referr	red to medical	111							26. Pla	ce of Dear	th (Check only		0 1	Yes	2□ No	
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o no			27. Manner of Death 1 □Natural	5 Pendin	ng		nth, Day	Year)	b. Time of		28c. Injury Work		5	28d. Describ	_ `	_			
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	To the within 2 To the complet	ž	29b. Signature and	title of certifie	or .	/	1	0.		2	9c. License	o number				_	-	Day, Year)	
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Funeral other treumatic event, the Medical Examiner must be notified at 5 Items 23a 6 al Hygiene. should be f and Mental I

NAME: Dirsmore, Mirtam

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed P.O. Division of Vital Records,

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** SEPTEMBER 6, 2005 MIRIAM LORRAINE DINSMORE 5:50 PM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** REEDERS MEMORIAL HOME **BOONSBORO** WASHINGTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JUNE 15, 1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min 1 □ M 2 🖾 F 82 Yrs. 216-14-6079 MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No Director MARYLAND WASHINGTON BOONSBORO 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 141 SOUTH MAIN STREET 21713 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 X Widowed 4 □ Divorced WHITE16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 COAT MANUFACTURING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be IRA EDWARD RICE LOLA SOPHIA KEEDY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Importent: If item 27 is
eny injury or other treu DONALD DINSMORE/SON 20608 VIOLET ROAD, ROHRERSVILLE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2 ☐ Cremation 3 ☐ Removal from State 1 X Bugiel-5 ☐ Other (Specify) 09/09/2005 ROHRERSVILLE, MARYLAND 4 Donation PLEASANT VIEW CEM. 22. Name and Address of Facility
BAST FUNERAL HOME 21. Signature of 7606 Old National Pike Paul M. Dean Boonsboro, Maryland 21713 Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final **Physician** sorbalile cerelino disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner frany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manngrof Death 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 29c. License number D325K 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21756/ 301-432-2222 21 WYAND DRIVE, KEEDYSVILLE, MD ROBERT GUEDENET 31. Date filed (Month, Day, Year) 32. Ragistrar's Signature State SEP 08 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

State Registrar

31. Date filed (Month, Day, Year) SEP 0 2 2005

Neelan Ashai

Registrar's Signature.

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74/LAVE

landover Hills

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Ŕ. Darling August 34° 2005° 11:15P. M Patricia **Physician** /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Adelphi Hillhaven Assisted Livjng,Nursing&Pehab Ctr. If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Yeer) 6. Sex **Funeral** Months Days Hours 1 M 20 F 95 216-44-3747 Jan. 9, 1910 Virginia Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in then "netural", or items 23a or 28a-f show the Medical Examiner intal by indiffied at 1 ☐ Yes 2 XNo Beltsville Maryland Prince George's Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20705 United States 5209 Cochran Road death by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No White Baltimore, Maryland 21215-0036 3€ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If I tem 27 Is marked other then eny injury or other traumatic event, It a M. Purchasing Agent Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gertrude Edwards Edward Young 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 5209 Cochran Rd. Beltsville, Maryland 20705 Floyd E. Pennett - son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Memorial Park 9/3/2005 Easton, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signalur of Fune a Service Ucensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 Tremas 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dementia resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel dea
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 2 Fetal death Day Year in the past 12 months? Month 5 Other (specify) detached the 9 Unknown by 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Hypertension be 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy репогл 2X No 1 Yes 1 ☐ Yes 2 ☐ No certificate Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certification: After Injury 1 X Natural 5 Pending 1 Tes 2 No death. investigation 2 Accident after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide within 24 hours a ሼ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. å 29d. Date signed (Month, Dey, Year) 29b. Signature a d'title of certifier D0031563 September 1, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Benner, 10801 Lockwood Drive, #205 Silver Spring, Maryland 20901 M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 2005 parts SEP 0 Registrar

State of Maryland / Department of Health and Mental Hygiene 30243 For State Registrar Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) SEPT. 4, 2:18 AM M **Physician** DE MARR SYLVESTER HENRY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL CENTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, DEC 20, 6. Sex 14 M 2 ☐ F 7. Age (In yrs. last birthday) 5. Social Security Number Months **Funeral** MARYLAND 76 218-24-7180 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No BRANDYWINE Director CHARLES MARYLAND 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number UNITED STATES 20613 16205 WILKERSON PLACE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 Never Married 2 Married 1 ☐ Yes 2X No ò Specify: Specify: Maryland 21215-0036 WHITE 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) SAND & GRAVEL Elementary/Secondary (0-12) College (1-4or 5+) other than HEAVEY EQUIPMENT OPERATOR COMPANY 3 18. Mother's Name (First, Middle, Maiden Sumame) in ury or other traumatic event, 17. Father's Name (First, Middle, Last) Department of Health and Mental Important: If itam 27 is marked o any in lury or other traumatic eve pe IDA MAE THOMPSON NORMAN HENRY DE MARR Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16205 WILKERSON PL., BRANDYWINE, MD 20613 ELLA MAE DE MARR - SISTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition

→ Burial 2 □ Cremation 3 □ Removal from State SEPTEMBER TRINITY MEM. GDNS. WALDORF, MARYLAND 9, 2005 A □ Donation 5 □ Other (Specify) permit 21. Signature of Funeral Service Licensee M00053 HUNTT FUNERAL HOME P.O.BOX 156, WALDORF, MARYLAND 20604 Yau Shau 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): use as the burial-Box 68760, the attending physician Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 🗆 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 20 1 Yes certificate or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3□ DOA 2 1 2 ER/Outpatient Certification: To 1 Yes this after death.

I Diractor: After this d in by the funeral di 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 1 Deatural 5 Pending 1 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled within 24 hours a To tha Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number and title of certifier 29b. Signati 2 erson who completed cause of death (Item 23a) (Type, Print) ne and address ver Spring Day, Year) 0 State 0 6 2005 Registrar

1- State of Maryland / Department of Health and Mental Hygiere 1 per Dr., G849, 11/09/05dhb Registrar 30244 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 26 2005 Physician PELAGIA CORDOVA August 9.20 AM DALIDA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arunde] 8. Date of Birth (Month, Day, Year)
Jul. 28, 1930 Philippines If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 SF Yrs. 75 Director 583-84-8553 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28s-1 show the Madical Examiner must be notified at Director MD Anne Arundel Severna Park 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 Cypress Ridge Drive 238 21146 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Philipino Š Specify: 3 Widowed 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Bank of College (1-4or 5+) 5+ Elementary/Secondary (0-12) Clerical America permi. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: if item 27 is marked other th sny injury or other traumatic svent, Im once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lorenzo Cordova Juanita Maypa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony C. Dalida/Son 205 Cypress Ridge Drive, Severna Park, MD 21146 Aug. 31, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Colma, CA Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** (tspiRATION PRIEUMONIA /Medical Due to (or as a consequence of) Examiner ZEHIMER'S DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) //代//#// Annk Annk/ Division of Vital Records, P.O. Box 68760, sicien Completed by Physician/Medical ate has been signed by the attending physpage 2 should be detached for use as the use as the 23c. If yes, outcome of pregnancy
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1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 2 No 1 Yes 2/S No 1 Yes 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No Hospital: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending investigation ours after death.

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 26 2005 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7845 Oakwood Road, 103 alon Burnie, K. Ambalavanov 31. Date filed (Month, Day, Year) 32. Refistrar's Signature State AUG 3.0 2005 Registrar

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		Lynne Dorn	(Daughter)	P.O.	Box 357	, Crumptor	n, MD 2	1628	
Department of Health Important: If item 27 any injury or other troops		20a. Method of Disposition	on 3 □Removal from State	20b. Place of Dispo			Date	20c. Location - City o	r Town, Stete
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Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygie 20 0 5 30246 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ruth E. Dyer 28, 2005 August 6:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Heritage Harbour Health Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 12-25-1920 7. Age (In vrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F Director 577-16-6907 Maryland 84 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d, Inside City Limits 10b. County 27 is markad other than "natural", or itams 23a or 28a-f show traumatic evant, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 2nd Street 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary State of Maryland 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) d 2 should be fill h and Mental H 7 is marked oth Albert Ashby Ethel Lockhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If itam 27 is n any injury or other traun once. Anita M. Reno/ Daughter 110 2nd Street, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🄀 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 9-1-05 Suitland, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or a Examiner a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a curisequence of Examiner burial-transit Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760 Physician/Medical as the the attending IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 20 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Voursing Home 5 Residence 6 Other (Specify) 2 No 0 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 27. Manner of De th 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. a Funeral Diractor: After t 1 Natural 2 Accident 5 Pending 1 🗌 Yes investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier roton Medial Certi, Cofto, MD 2114 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nusaire egiskar's Signature State Registrar

ORIGINAL

			1 - State of Marylan		artment of H			iene 2.00	5 30247
	Physici		1. Decedent's Name (First, Middle, Last) James D. Daugherty, Jr.				2. Date of Deat Month	Day	3. Time of Death 9:35 p M
	/Medio Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	Septem	dc. County of	200.3
			2707 Aspen Drive		Ham	pstead		1	arroll
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 1978-24-5871 17. Mg 2□ F 79	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Apr 22,	Year) 1926	Birthplace (State or Foreign Country) Washington DC
	put 🚜		Usual Residence of Decedent	y, Town or Lo	cation				10d. Inside City Limits
	Maryla 1-f sho	to	Maryland Carroll	, 1011110120	outon	Hampstea	ad		1 ☐ Yes 2X No
	vith the	Director	10e. Street and Number		10f. Zip Code	21074	10	Og. Citizen of Wh	•
	death v	Funeral	2707 Aspen Drive 11. Marital Status 12. Was Decedent Ever in U.	.S. 13. V	Was Decedent of H	21074	ecify Yes or No-	US 14. Race	American Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If itam 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic avant. The Madical Examiner must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WWI.	_ .	fYes, specify Cuba 1 ☐ Yes 🎉 No	ispanic Origin? (Sp. in, Mexican, Puerto Specify:	Rican, etc.)		White, etc. White
2-0	72 hou natura		15. Decedent's Education (Specify only highest grade completed)	(Give	ient's Usual Occup	during most of work	ina 1	16b. Kind of Busi	ness/Industry
Maryland 21215-0036	l within iene. r than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	00 NOT use retired Accountan	0		Cons	truction
nd 2	al Hygie I other vant. II	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, N	faiden Sumame)	
ryla	2 should be and Mental is marked o	P	James D. Daugherty, Sr. 19a. Informant's Name/Relationship (Type, Print)	10h Mailia	Address (Chron	Mary F		O' T O	7.0.11
	and 2 sl ealth and m 27 is r her traur		James A. Daugherty, son			and Number or Rura ne, Waldo			afe, Zip Code)
Baltimore,	ges 1 ar it of Hea if itam or other		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	emetery, cren	sition (Name of natory or other plac	e)			ity or Town, State
altim	t. Pa rtmer rtant njury		'4 Donation 5 Other (Specify) Cec 21. Signature of Funeral Service Licensee 772.3		L1 Cemete . Name and Addres		8/2005 Eline Fu	Suitla	·
ä	Depa Impo any i		Stever WZ lin			Main St,	Hampste	ad, MD	
			23a. Part1. Enfer the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final					st,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Metasta h Due to (or as a consequence)		D c dde	Cance			320
	Examiner	1	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of the conditions)	10000 of					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ierice dij.					
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Box	n cer andin use	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal	death 3	Ectopic pregnancy			23d. Date of	
0	that the death ed by the atte detached for	hysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of de 9 ☐ Unknown 9 ☐ Unknown	ath 5	Other (specify)				. 54, 754.
<u>s</u> , P	Se uf		Part II. Other significant conditions contributing to death but not resu		nderlying cause give	en in Part I.			ute to the cause of death?
Sorc		eted	Coronary Arten Direa	16			24a. Was an		Probably 4 Unknown
of Vital Records	S 53 8	Completed by	The tension				autopsy perform	ed? pric	re autopsy findings available of to completion of cause of atth? Yes 2 \textstyle \text{No}
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Division	I o r Attending Ph after death. Diractor : After th I in by the funeral	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	eet and Number State)	or Rural Route Number,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my know and manner stated.	wledge, death ion and/or inv	occurred at the time	ie, date and place, a pinion, death occurr	and due to the car ed at the time, da	use(s) and mann te and place, and	er as stated. If due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier		29c. License		29	. 1 / 1	Month, Day, Year)
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	6			M4100	In Dr.	, Sv. A.	304; W.	estminst	E, MD 21157
: ~	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 7 2005	ure	Sperke				

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 04, 2005 Year Cornelia Ann Doolan Physician 2:55 P. /Medical 4c. County of Death Affegany 4a. Facility Name (If not institution, give street and number) 19300 Paradise Hill Lane 4b. City, Town, or Location of Death Midland Examiner If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 01, 1943 Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕱 F 220-40-1228 62 Director Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. snt: If item 27 is marked other than "neturel", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location of Health and Mental Hygiene.
item 27 is marked other than "neturel", or Items 23a or 28a-f show other treumetic event, "so Nedical Examinational to notified at Allegany Midland Maryland 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21542 19300 Paradise Hill Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hair Beautician 12 18. Mother's Name (First, Middle, Maiden Surpame, Catherine Fair 17. Father's Name (First, Middle, Last) Be John Cesnick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Importent: if item 27 is any injury or other treu once. Bobbie Ann Kirkwood - Daughter 17606 Old Dans Rock Road, Frostburg, Maryland, 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Midland, Maryland 08, 2005 St. Josephs Catholic Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home 8 East Main St., Lonaconing, MD. 21539 Ĺ 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardio Vascular disense Pnysici<u>a</u>n 6 months /Medical Examiner Athero sclerosis 2 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑No certificate 2 No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No death. Director: in by the ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Dire 4 \ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 00055325 works D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Terrace Frostburg MD21532 MD SHIN 48 Tarn wo Nso de 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2005

05-5788 B.K.S PROBIR I

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

COSTA	1 - For State Registrar	State of Ma		epartmer <i>Certificat</i>			Mental H	ygiene Reg. No.	CUU.	30250		
sician	Decedent's Name (First, Middle						2. Date of I Month	Day	y Year	3. Time of Death		
edical	Probir		Costa	Ah City	Town or	Location of Dea	AUG.			4:19 A		
miner	4a. Fecility Name (If not institution, WASHINGTON ADV			TAK	.OMA	PARK			County of De MONTGOM			
al or	5. Social Security Number 040-08-2726 Usual Residence of Decedent		e (In yrs. last bir	Yrs. If Unde Months	Days	If Under 24 Hr Hours Mir	S. 8. Date of E (Month, I March	Day Year)	955 Bar	irthplace (State or Foreig Country) ngladesh		
	10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limit		
ctor	Maryland Prince	George	orge Adlephi							1⊠Yes 2□N		
Funeral Director	10e. Street and Number 1826 Metzerott	Dd IInde AOS)	10f. Zij	20783		izen of What C nglades					
erai	11. Marital Status	12. Was Decedent		13. Was Dece			(Specify Yes or Nerto Rican, etc.)		14. Race - Am			
þ	1 Never Married 2 Marri 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	es 2⊠No ,Give 1⊑			n, Mexican, Pue Specify:	erto Rican, etc.)	Black, White, etc. Specify: Asian				
eted	15. Decedent (Specify only highes		16a.	Decedent's Usu (Give kind of wo	al Occupa	ation during most of w f)	orking	16b. Kind of Business/Industry				
Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Tife. DO NOT u		()		Food				
Be	17. Father's Name (First, Middle, I Paul D'Costa	ast)					ame (First, Midd		Sumame)			
70	19a. Informant's Name/Relationship (Type, Print) Shamoli D'Costa/Wife 19b. Mailing Address (Street and Number or Rural R								Route Number, City or Town, State, Zip Code)			
	20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 □Remoyal from State	20b. Place of cemeter	Disposition (Na. y, crematory or c	me of other plac	(9)	Date	20c. Lo	ocation - City o	or Town, State		
To Be Completed by Funeral Director	4 Donation 5 Other (Sp. 21. Signature of Funeral Service L		Gate o	22. Name a			. 2,2005 Pope_Fun			LING		
ä	+Kouta	Samo of	21015				11315 Lo Silver S	ckwoc	od Driv	e 20904		
dicai Examiner	Immediate Cause (I-inal addissass or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
Medi	IE CEMALE.	1										
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)								23d. Date of delivery Month Day Year			
by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did to								bacco use contribute to the cause of death?			
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Be	25. Was case referred to medical examiner?	Hospitali			104		eath Chick only	one)				
2	1)XXYes 2 □ No 27. Manger of Death	Hospital: 1 Inpatie				4 Nursing	Home 5 ☐ Re			ecify)		
ation	Natural 5 Pending investig	ation	y Year)	njury M	28c. Injun Work 1 🔲 '	Yes 2 □ No	200. Describe	28d. Describe how injury occurred				
Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 289. Place of Inj	ury - At home, fa c. (Specify)	rm, street, factor	y, office			(Street an own, State		Rural Route Number,		
edicai	29a. Certifier 1 Certifyin (Check only one)	Physician: To the best examiner: On the basis of and manner sta	examination and	, death occurred d/or investigation	at the tim	ne, date and place pinion, death occ	ce, and due to th curred at the time	e cause(s) e, date and	and manner a place, and du	as stated. ue to the cause(s)		
×	29b. Signature and title of certifier	11	2	29		• number • M • E		29d. Dat AU	te signed <i>(Mor</i> JG. 28,	nth, Day, Year) 2005		
	30. Name and addreg of pers	M.C. A.DOL	s 11th PI	INN STRE	ET,B	ALTIMORI	E,MARYLA	ND 21	201			
State	31. Date filed (Month, Day, Year)	32. Registr	a s Signature									
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygie 2005 1 - For State Registrer 30251 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Rosalie Elizabeth Dobbin /Medical August 26, 2005 1:30A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Layhill Nursing Center Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2 😾 F 90 Director 215-24-8876 Yrs Feb. 8, 1915 Maryland Usual Residence of Decedent Maryland 10a State 10b. Count 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic avant, the Medical Examiner must be notified at Directo 1 ☑ Yes 2 ☐ No Maryland Montgomery Silver Spring the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3227 Bel Pre Road 20906 or Itams 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No þ Specify: Black 3 Widowed 4 Divorced natural ed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Complet Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 d 2 should be filed w h and Mental Hygier 7 is marked othar th Nanny/Housekeeper Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: if itam 27 is marked c any injury or other traumatic ave 20.08. Charles D. Dobbin Rosalie M. Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann D. Bulls/Sister 1218 45th P1. SE. Washington, D.C. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Resurrection Cemetery Sept. 3, 2005 Clinton, MD. 22. Name and Address of Facility 21. Signature of Funeral Service Acenses Pope Funeral Homes 23a. Part 1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List only one cause on each line. 5538 Marlboro Pike Forestville, MD. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Advanced Dementia years /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and -trans Due to (or as a consequence of): attending physician a for use as the burial-Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Tetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Cardiomyopathy 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? of Vital 1 Yes 2X No or Attanding Physician: the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☒ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending death. 2 Accident investigation 1 Yes 2 No after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral 6 filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Tigg Certarying rinysteer. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D38262 August 30, 2005 a cress of person who completed cause of death (Item 23a) (Type, Print) Anurita Mendhiratta, M.D. 2401 Research Blvd. Suite 330, Rockville, MD. 31. Date filed (Month, Day, Year) State SEP 0 1 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 2005 30252 1 - For State Registrat Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** A M 2005 1:40 Melva Naomi EICHELBERGER September 6 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Avalon Manor Nursing Home Washington Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Unde If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours Months 1 ☐ M 2 🗓 F Jan. 4 1909 Director 214-09-0131 96 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Show the Medical Examiner must be notified at 1 ☐ Yes 21 No Director or 28a-f s Maryland Washington <u>Hagerstown</u> 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a 17511 Dawn Drive 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: ģ 3 X Widowed 4 □ Divorced White "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Administrative Secretary Shoe Manufacturing other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill iment of Health and Mental H lent: If item 27 Is marked oth Be Bessie A. Baxter Irvin Eavy Nunamaker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ronald Nunamaker - Nephew 11915 Sunset Strip, Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ŏ permit, Page Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery | Sept. 9, 2005 Hagerstown, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congentin Heent Physician 7-1000 /Medical Due to (or as a consequence of): **Examiner** Anteno Scherte Condianarale Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown Records, P. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? bleed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 1 NO Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No hours after death, unerel Director: A 2 Accident the 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a
To the Funerel C
completely filled i Hospital 1 Destrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier -ONE MO P) 08) a SEPT 6 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo 21745 MAGERSTOWN 05H-5 MILLST VASLAVE DATTA MO 340 31. Date filed (MonSEP (Par)) 32. Jegistrar's Signature 2005 State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Department of Health and Mestate Registrar 8/31/05 AACD HEALTH DEPT. ONL Certificate of Death	ental Hygie	2°005 30253
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Last)		Day Year 3. Time of Death 29 2005 1348 M
	Funeral Director		216-68-8721 49 III. De	8. Date of Birth (Month, Day, Ye	Anne Arundel 9. Birthplace (State or Foreign Country) 1.955 Maryland
Maryland 21215-0036	es 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. I fitem 27 is marked other then "natural", or Items 23a or 28e-f show re other traumatic event, If a Mucical Examinar must be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Anne Arundel Annapolis 10e. Street and Number 232 Pindell Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Maryland Forces? 1 Marylan	g 16b (First, Middle, Maid Wells	ty or Town, State, Zip Code)
Baltimore, N	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		Evelyn Wells (Mother) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Real Folia the Acade Moo 43 24. Name and Address of Facility 25. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility 28. Real Folia the Acade Moo 43 29. Real Folia the Acade Moo 43 20. Real Folia the Acade Moo 44 20. Real Folia the Acade Moo 44 20. Real Folia the Acade Moo 45 20. Real Folia the Acade M	05 Ba	Location - City or Town, State 1 timore, Md.
	death certificate be executed Wedical e attending physician and for use as the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):	espiratory arrest,	Approximate Interval Between Onset and Death
o.	the death certific y the attending p iched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 9		23d. Date of delivery Month Day Year
Records, P	law requires that the de as been signed by the 2 should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 Tes	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
_	ysician: The s certificate h director, page	o Be Completed	25. Was case referred to medical examiner? 1 Yes No Hospital: Yopatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home		
VISION OF	Attending Physic death. ector: After this by the funeral di	Certification: T	27. Nanner of Death Natural 5 Pending investigation 3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Could not be determined 28f. Place of Injury - At home, farm, street, factory, office 28f. Could not be determined 28f. Place of Injury - At home, farm, street, factory, office 28f. Could not be determined 28f. Place of Injury - At home, farm, street, factory, office 28f. Could not be determined 28f. Place of Injury - At home, farm, street, factory, office 28f. Could not be determined 28f. Place of Injury - At home, farm, street, factory, office 28f. Place of Injury - At home, farm, street, factory, office 28f. Place of Injury - At home, farm, street, factory, office 28f. Place of Injury - At home, farm, street, factory, office 28f. Place of Injury - At home, farm, street, factory, office 28f. Place of Injury - At home, farm, street, factory, office 28f. Place of Injury - At home, farm, street, factory, office 28f. Place of Injury - At home, farm, street, factory, office 28f. Place of Injury - At home, farm, street, factory, office 28f. Place of Injury - At home, farm, street, factory, office Place of Injury - At home, farm, street, factory, office Place of Injury - At home, farm, street, factory, office Place of Injury - At home, farm, street, factory, office Place of Injury - At home, farm, street, factory, office Place of Injury - At home, farm, street, factory, office Place of Injury - At home, farm, street, factory, office Place of Injury - At home, farm, street, factory, office Place of Injury - At home, farm, street, factory, office Place of Injury - At home, farm, street, factory, office Place of Injury - At home, farm, street, factory, office Place of Injury - At home, farm, street, factory, office Place of Injury - At home, farm,	d. Describe how in	jury occurred and Number or Rural Route Number
בֿ	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After ti completely filled in by the funera	edicai Cert	29a. Certifier (Check only one) Did death occurred at the time, date and place, and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	City or Town, Sta	(c) and manner as stated
	To th within To th comp	Me	29b. Signature and little of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	29d. C	Date signed (Month, Day, Year)
ŀ	Sta Registr		31. Date filed (Month, Day, Year) AUG 3 1 2005 32 degistrar's Signature	1501	cal (Bull)

State of Maryland / Department of Health and Mental Hygiere 30254 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:1JA M Iva Virginia Fox 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coffman Nursing Home Hagerstown Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 X F Director 97 Yrs 214-46-5707 April 22,1908 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Everther must be notified at Director 1 ☐ Yes 2 No Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Example page. 21795 16512 Spielman Rd. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No à Specify 3 ₩Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Charles Mary Catherine Metz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda L. Fox - Daughter 18027 Pin Oak Rd, Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State, 4 □ Donation 5 □ Other (Specify) Greenlawn Mem. Park | Sept.6,2005 Williamsport, Maryland Funeral Service 21. Signature of OSBOPTE AFTERNETS Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oncet and Death Immediate Cause (Final disease or condition resulting in death) numous **Physician** /Medical Due o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause fusease or injury that initiated events Due to (or as a consequence of) Examine attending physician and I for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown Part II. Other significant conditions configuring to death buy not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available proof to completion of cause of death?

1 Yes 2 No autopsy 1 Yes 25. Was case referred to modical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner Certification: 28d. Describe how injury occurred After or Attending 1 atural 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determine 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Sign ture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMUEL CHAN, 324 E. ANTIETAM S 5H-1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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			1 - For State Registrar	State of M	aryland / Depa <i>Cel</i>	artment of H rtificate of L	ealth and I D <i>eath</i>		2005	30255
	Physic /Medi		Decedent's Name (First, Middle, L Margaret	^{ast)} Elaine	For	rd		2. Date of Death Month Aug. 26,	Day Yes 2005	3. Time of Death 1:30 AM ^M
	Exami		4a. Facility Name (If not institution, g. Spa Creek Cente			4b. City, Town, or Annapo		1	4c. County of D	
	Funeral		-	Sex 7. Ag	ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign
	Director		217-50-7664	1□M 2¶F	57 Yrs.	Months Days	Hours Min.	June 5,1	.948 Ma	aryland
	yland now		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation		-		10d. Inside City Limits
	Ba-f st	ctor	MD Anne A	rundel	Odenton					1 ☐ Yes XXX No
	with th	Dire	10e. Street and Number			10f. Zip Code		10g	. Citizen of What	Country?
	death ms 23	eral	1318 Treasure D	12. Was Decedent		Was Decedent of Hi	113 spanic Origin? (S	pecify Yes or No-		merican Indian,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel', or items 23a or 28a-f show mith figury or other treumatic event, it is Madical Examinar must be nutified at ance.	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4XXX0ivorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	If Yes, specify Cubai 1 ☐ Yes 2 X No	n, Mexican, Puerti Specify:	o Rican, etc.)	Black, W	white, etc.
2-0	"netur	eted	15. Decedent's I (Specify only highest g	Education rade completed)	(Give	dent's Usual Occupa	luring most of wor.	king 16	b. Kind of Busine	ss/Industry
21215-0036	withir iene. than	dwo	Elementary/Secondary (0-12)	College (1-4or 5	5+) Cash	DO NOT use retired; uiler)		Retail	
pd	al Hyg al Hyg I other vent, I	Be C	17. Father's Name (First, Middle, Las	it)	, oabii	1101	18. Mother's Nan	ne (First, Middle, Ma		
ylaı	ould b Menta varked vatice	10 E	Henry William Na					ret Young		
Maryland	id 2 sh lth and 27 Is m treum		19a. Informant's Name/Relationship Donald Coulling			-		ral Route Number, C Odenton,	•	
ē,	of Healitem	-	20a. Method of Disposition		20b. Place of Dispo				c. Location - City	
<u>iii</u>	Page ment c ent: If ury or		1 XBurial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spec		Glen Hav	en Cem.	8-29		len Burn	ie, MD
Baltimore,	permit. Depart Import any Inj		21. Signature of Funeral Service Lice		22	Name and Addres Hardesty 12 Ridge	s of Facility Funeral 1y Avenu	Home, P.	A. lis, MD	21401
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused y one cause on each li	d the death. Do not ent ne.					Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	a consequence of	COP	5			Short and South
B	Examiner		Sequentially list conditions	b.	a consequence of					
	ed sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		a consequence of):					
Ć,	execut in and ial-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
68760,	icate be executed physician and s the burial-transit	dlcal		_ d						
9 ×	eath certific attending pl	0	IF FEMALE:	23c. If yes, outcome	of pregnancy				004 Days 44	4-6
P.O. Box	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of o	Day Year
дs, Б	uires that signed b d be deta	by	Part II. Other significant conditions	contributing to death b	out not resulting in the ur	nderlying cause give	n in Part I.			to the cause of death?
Records,	w requir been si should	Completed	D/ S	yper 1 es	2500			24a. Was an		autopsy findings available
Be	The lav	omp	fullmonery &	1 50 (13 m				autopsy performe 1 Yes 2	d? prior t	o completion of cause of
Vital	ician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?					th Check only one	(40)	63 2010
of	ding Physician: The h. h. After this certificate h. funeral director, page	2 2	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie			4 Walvursing H	ome 5 Residence		pecify)
on	nding F ath. r: After e funer	atlon	1 Natural 5 Pending 2 Accident investigation	(Month, Da)	y Year) Injury	Work	? ′es 2 □No	200. Describe now	injury occurred	
Division	For Attendiater death. Director: A lin by the fu	Certification:	3 Suicide 6 Could not 4 Homicide determined	28e. Place of Injuding, et	ury - At home, farm, stre c. (Specify)	eet, factory, office		28f. Location (Stree City or Town, S		Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certifical completely filled in by the funeral director,	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	hysician: To the best miner: On the basis of and manner sta	of my knowledge, death f examination and/or invated.	o occurred at the time restigation, in my op	e, date and place, inion, death occur	and due to the caus red at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Mo	nth, Day, Year)
)			1 feet	~		DLIS			8/26	12005
			30. Name and address of person who REYNALLO CEE - 31. Date filed (Mooth, Day, Year) 2	completed cause of d	leath (Item 23a) (Type,	Print)	ai i	411	211	C
	Sta	te	31. Date filed (Month, Day, Year)	OOF 32 Registr	ar's Signature	oneto Dr	y chest	e Mi)	2161	4
	Registi		AUG 3 1 2	UUD CUU	w & B	me of				

State of Maryland / Department of Health and Mental Hygi 30256 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Margaret Belva Froelich August 28 2005 /Medical 8:35 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 407 Bedford Street Cumberland Allegany If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y 03/22/1917 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖾 F 88 Yrs. Director 220-10-7580 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location 27 is marked other than "natural", or Items 23e or 28e-f show traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Allegany Cumber land 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13716 Bedford Road, N.E. 21502 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinant 2008. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cook Monroe Lucretia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James V. Froelich / son 1259 Bedford Valley Road, Bedford, PA 15522 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗵 Burial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Sunset Memorial Park 08/31/2005 Cumberland, Maryland 21. Signature of uneral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, Maryland 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the m, de of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** MRS disease or condition resulting in death) /Medical Due to (or as a construction of): Examiner Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events as the burial-transit certificate be executed the attending physician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown ۾ certificate has been signed t rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2**X** No 2 No 1 ☐ Yes Hospital or Attending Physicien: 24 hours after death. Funerel Director: After this certifice funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Living 2 No 2 1 🗌 Yes 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D22181 August 29, 2005 ć 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 Bishop Walsh Drive, Cumberland, Maryland Gary L. Wagoner, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 2 9 2005 Registrar

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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie**7**e 005 30258 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Aufaüst 2005 **Physician** 10:05A M Juanita Garner /Medical 4a Fecility Name (If not institution, give street and number)
Genesis Elder Care @ Spa Creek 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Annapolis Anné Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Min. | March | 8 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🔽 F 99 301-36-6287 1906 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10b. County 10a State TRIYES 2 No Annapolis Maryland Anne Arundel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21401 1809 Schooner Ct. USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No 1 ☐ Yes 2 No Specify: Specify: Black Completed by If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Ft. Belvoir 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Hebron Emma Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Catherine Samuels(Daughter) 809 Schooner Ct. Annapolis, Md. 21401 20b. Place of Disposition (Name of H Leinetery, Cramercal or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XBurial 2 ☐ Cremation 3 ☐ Removal from State 9-2-05 Annapolis, Md. Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
Wm. Reese & Sons Mortuary, 21. Signature of Funeral Service Licensee Larry S. Keese MOOY 83 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner eshuo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 10 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Natural 2 Accident 1 Yes 2 No after death Diractor: / 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check one) Medical 29d. Date signed (Month, Day, Year) 29b. Signat e and title of certifier 29c. License number

within 24 hours a To the Funeral D

State Registrar



ddress of person who completed cause of death (Item 23a) (Type, Print)



AVESTE 231

State of Maryland / Department of Health and Mental Hygiene 0 0 5 30259 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month August 25, 2005 **Physician** 8:30 p M Gamble Linda /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Clinton Prince Georges Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. May 4, 196 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🖾 F North Carolina Director 577-98-8924 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State ral', or items 23e or 28e-f show Examiner must be notified at Suitland ¥☐Yes 2 ☐No Prince George Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20746 2407 Darel Dr. Apt. #T-4 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1- Never Married 2 Married ☐Yes 2√∑No Yes. Give Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2x No Specify: Specify: 3 Widowed 4 Divorced "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) treumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Law Firm Executive Assistant 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: If item 27 is marked othe any injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carolyn Easterling Norther Gamble ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2407 Darel Dr. Apt.T-4 Suitland, Md. Sade Gamble / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Sept.3,2005 Alexandria, Va. 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan 22. Name and Address of Facility
Alexander S. Pope Funeral Homes, P.A.
5538 Mariboro Pike/Forestville, Md. 20747 21. Signature of Funeral Service Licensee 23a. Part1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBRAL INFARCTION **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/MedIcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ∰Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 3 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 🖪 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 0 8 6 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AUGUST, 26, 2005 30. Name and address a person who completed cause of death (Item 23a) (Type, Print) 9831 Greenbelt Rd. S-103 Lanham, Md. Sherif Hassan, M.D. 31. Date filed (Month, Day, Year) . Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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State of Maryland / Department of Health and Mental Hygier 2005 30260 For State Registrar Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day
SEPTEMBER 2. **Physician** 2005 4:30 A M John Ralev Garner /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1/2 M 2□ F Yrs Director 579-12-9618 May 18,1921 Leonardtown MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f shov the Madical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Anne Arundel Davidsonville 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1504 Manor View Rd. 21035 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ty Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√€ No Specify: þ White 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) markad other than Draftsman Civil Service 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental I ant: If item 27 Is markad o Virginia Raley Benjamin M. Garner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pamela Garner Summerall/ Daughter 1504 Manor View Rd. Davidsonville MD 21035 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once. Brinsfield-Echols Crem. 9/6/2005 Charlotte Hall, MD 21. Signature of Funeral Service Licensee-22. Name and Address of Facility Brinsfield Funeral Home PA. Kyle S. Simons M01206 22955 Hollywood Rd, Leonardtown MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Phenhomo **Physician** /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit nnow and Due to (or as a consequence of) attending physician Physician/Medical use as the 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Dav 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 Records, Completed by 1 Yes 2 No 3 Probably 4 MUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificete has 2 No 1 Yes 2 Z NO Vital funeral director. 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1\ Impatient Certification: To 1 Tyes 21 No 2 ER/Outpatient 3 DOA ō this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28b. Time of After Division 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ö Ecrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only 29d. Date signed (Month. Day, Year) 29b. Signature and title of celtifier 29c. License number D60 888 05 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person SHANTI MEDICAL CENTER LEONARDTOWN, MARYLAND 20688 DR. RAKHI KRISHNAN State

DHMH 17 Rev 1/200

Registrar

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2005

State of Maryland / Department of Health and Mental Hygiene 30261 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 **Physician** Month August 30, Joanne Greenfield 4:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Ft. Washington Hospital Ft. Washington Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Sept. 23, 1949 | 9. Birthplace (State or Foreign Months | Sept. 23, 1949 | Washington DC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🕄 F 55 Director 578-66-6364 Yrs. Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral', or items 23a or 28a-1 shov Completed by Funeral Director 1 ☑ Yes 2 ☐ No MD Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3410 Brinkley Rd #302 20748 United States death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after of the short of Health and Merial Hygiene. and if it is marked other than "natural; or the ary or other traumatic event, the Merical Estain and yor other traumatic event, the Merical Estain and the support of the State Black, White, etc. 1 ☐ Yes 2€XNo If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes XXNo 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Program Support Assistant Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John William Greenfield Vernita Bigby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daryl Willis /Son 7 Alexanderia Overlook Oxon Hill MD 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or Harmony Cemetery Sept 7, 2005 Landover MD * 4 ☐ Donation 5 ☐ Other (Specify) on we of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Home 2617 Penn Ave SE Washington DC 20020 Approximate Interval Between Onset and Dath Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrestal shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Little of the design of cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth: 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 ☐ Yes 20 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 KNo 1 Inpatient 2 ER/Outpatient 3 DOA in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending after death, I Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 31-2805 Name and address of person who aproplete cause of death (Item 23a) (Type, Print) 4mi-Mirza Alikhani 31. Date filed (Month, Day, Year) State 0 1 2005 Registrar

			1- State Amend Item	State of per m	of Maryla e G847	nd / Depr 28-0 Cer	rtmen Eas tificate	t of Ho	ealth and <i>Death</i>	Mental Hy	giene 0	05	30262		
3	Physici	an	Decedent's Name (First, Middle, La	st)						2. Date of Dea Month	ith Day	Year	3. Time of Death		
	/Media	al	LILLY GRI							August	29	2005	12:45 P ^M		
1-	Examir	ier	4a. Facility Name (If not institution, give		imber)				Location of Dea	ith		inty of Death			
	Funeral		Holy Cross Hospit		7. Age (In yrs	s. last birthday)			pring If Under 24 Hr	s. 8. Date of Birtl		gomer	y place (State or Foreign		
Say	Director		577-48-0438	□ M 2600F	93	Yrs.	Months	Days	Hours Mir	Nov. 11	r, Year)	Po1	intry)		
	pu ,		Usual Residence of Decedent							NOV. II	1911	FUL	and		
	anyla •hov	2	10a. State 10b. County			City, Town or Lo						Ì	10d. Inside City Limits		
	the M	ecto	MD Montgome 10e. Street and Number	ery		Silver							1 Tes 2 No		
	with Sa or	<u>D</u>	4 Saddlerock Cour	ct			10f. Zip	20902				of What Cou			
	72 hours after death with the Maryland natural; or Iteme 23a or 28a-1 ehow dical Examiner must be mullied at	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13. \				Specify Yes or No-		Race - Ameri			
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Maryland	2 should be f and Mental h le marked of raumatic ever	To Be	Joshua Benjamin H	lein						Schloct		uo,			
ary	shou and N man	_	19a. Informant's Name/Relationship (19b. Mailin	g Address	(Street an		ural Route Number		vn, State, Zij	Code)		
	bs 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental hygiene. Item 27 ie marked other than "natural", or iteme 23a or 28a-f ehow other traumatic event, the Madical Experiment must be rutilled at a context of the contex		Sidney Gritz, Son							Silver S					
ore	ages 1 int of Hi t: If iter		20a. Method of Disposition 1	Removal from	- 1	Place of Dispos cemetery, cren	sition (Nam natory or oti	e of her place,	}	Date	20c. Locatio	n - City or To	own, State		
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Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice		Home, Inc. MD 20904										
· ·	5		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximat												
	Physician		Immediate Cause (Final disease or condition	а	Acut	e Renal	Fail	ure				1	Onset and Death		
	/Medical Examiner		disease or condition resulting in death) a Acute Renal Failure Due to (or as a consequence of):												
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	To the Hospitel of within 24 hours af To the Funerel D completely filled in	Me	29b. Signature and title of certifier	and man	ner stated.			License r				ned (Month, I			
	2		Kshar	ng a	rans	MD	D	6082	6			29, 2			
	7		30. Name and address of person who	completed caus	e of death ter	n 23a) (Type, P	rint)	-							
			Kshama Garg, M.D.	1500 Fc	orest G	len Roa	d, Si	lver	Spring	, MD 2091	.0				
**	Stat Registra	٠,	31. Date liled (Month, Day, Year) AUG 3 1 2	000	egistrar's Signa	ature 400	seles.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygieze 05 30263 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month 11:00 AM 25, 2005 Rosalie Gerber August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3330 North Leisure World Blvd Silver Spring Montgomery If Under 1 Year If Under 24 Hi 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours Min. 1 M 2 StF 80 109-16-6824 5, 1925 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes 2 No Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14. Race - American Indian, 3330 North Leisure World Blvd. 20906 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2¥ No Yes, Give 1 Never Married 2 Married 1 Tes 2 No Specify: If Yes, Give Year or Dates: Specify: White 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Scheer Harry Schne Hana Reiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claudia Barnett/Daughter 6127 Long Meadow Rd., McLean, VA 22101 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Toremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 08/29/05 Brentwood, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service Licensee Myelin 11800 New Hampshire Ave; Silver Spring MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Chronic Obstructive Pulmonary Disease Years Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4☐ Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 X No

Physician /Medical Examiner

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To the Hoepital or within 24 hours at To the Funeral D

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Certification:

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Division of Vital Records, P.O. Box 68760,

Physician:

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Physician

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27 le marked othar than "natural", or Items 23a or 28a-f ehow traumatic event, ils Madical Examirar o ust be notified at

2 should be filed within 72 hours after death with to and Mental Hygiene.

Baltimore, Maryland 21215-0036

the Maryland

Sequentially list conditions, if any, leading to immediate cass. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Examiner Physician/Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

3 Suicide

(Check only one)

29a. Certifier

25. Was case referred to medical examiner' 1 ☐ Yes 2X No

27. Manner of Death 5 Pending 2 Accident

investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes

26. Place of Death (Check only one)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

and manner stated

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1X Certifying Physiciant To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

August 25, 2005

D08381 un

30. Name and ordres of person of mpleted cause of death (Item 23a) (Type, Print) Ben Azrunijn, M.D., 1811 Prince Philip Dr., Olney, MD 20832

State Registrar

31. Date filed (Month, Day, Year) 2005



4ELEN 000 8-12-23 55# 215 20 4763 HAMMOND, HELEN

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			Registrar 1. Decedent's Name	a (First Middle La	et)		Cei	uncate or	Deaiii	2. Date of D	Reg. No.		3. Time of Death
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E	Examin	er			e street and number)				or Location of De	ath	4c. County		
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yland	MOI I		10a. State	10b. County		10c. City, To	wn or Lo	cation				T	10d. Inside City Limits
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h with th	23a or 28 at be no	ai Director	10e. Street and Nur 10206		ANDING ROA	ΔD		10f. Zip Code 218	313		10g. Citizen of V USA	√hat Cou	untry?
III G Z I Z I 3-0000 be filed within 72 hours after death with the Maryland tal Hygiene.	if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Exertiner must be notified at	Funerai	11. Marital Status	ied 2 Married	12. Was Decedent Armed Forces? 1 □ Yes 2 📉		1			(Specify Yes or N erto Rican, etc.)	Blac	k, White,	ican Indian, , etc.
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LIVISION OF VICE To the Hospital or Attending Physician: within 24 hours after death.	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 Suicide 4 Homicide	6 Could not b	28e. Place of Inj	ury - At home, i c. (Specify)	farm, stre	eet, factory, office		28f. Location City or To	(Street and Number iwn, State)	er or Run	al Route Number,
e Hospit	se Funera	Medical (29a. Certifier (Check only one)	1 Certifying Ph 2 Madical Exam	nysician: To the best niner: On the basis of and manner sta	f examination a	ge, death and/or inv	n occurred at the t vestigation, in my	ime, date and pla opinion, death oc	ice, and due to the curred at the time,	cause(s) and mar date and place, a	nner as s	stated. to the cause(s)
To th withir	comp	M	29b. Signature and	title of certifier	ek			29c. Licen	se number	3	29d. Date signed	(Month)	Day, Year)
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		•	For State Registrar	State of M	•	•	rtment of He		Mental Hyو ا	gienz 0 0 5	30265
			Decedent's Name (First, Middle, Last	0					2. Date of Dea	ath	3. Time of Death
	Physicia		Clyde Edwin	Hamilton					Septemb	er ^{Day} , 200	3:00 A M
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town, or	Location of De	ath	4c. County of E	Death
			3511 Patuxent Roa				Hunting			Calve	
	Funeral		5. Social Security Number 6. Se	x 7. A	ge (In yrs. last birti	hday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		h y, Year) 20 1026	Birthplace (State or Foreign Country)
	Director	.	218-34-6297 Usual Residence of Decedent		69	113.			April	20, 1930	Marýland
	land ow		10a. State 10b. County		10c. City, Town	or Lo	cation				10d. Inside City Limits
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	th the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	t Country?
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	tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	- 14. Race - A Black, V	American Indian, White, etc.
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Вох	death certifica e attending pt ed for use as t	Physician/Me	23b. was decedent pregnant	23c. If yes, outcom 1☐Live birth	e of pregnancy 2 Fetal death	3 🗆	Ectopic pregnancy			23d. Date of Month	f delivery Day Year
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Re	The lav	ш							autop perfo	rmed? prior	r to completion of cause of th?
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	24 hos Eun etely	Medical			of examination and					date and place, and	
	To the Hospital or Attending Ph within 24 hours after death. To the Funarel Diractor: After th completely filled in by the funeral	Me	29b. Signature and title of certifier				29c. License	number		29d. Date signed (A	Month, Day, Year)
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			30. Name and address of person who	completed cause of				P	4	2.1	- 05 , MD 20678
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	Sta Regist		31. Date filed (Month Day Year) 6	2005 32. Redis	trans Signature		barles				
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State of Maryland / Department of Health and Mental Hygien 0 0 5 30266 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Rosetta J. Harris 25, August 10:22 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 29, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 9. Birthplace (State or Foreign 1 M 2 X F 80 1925 Washington, DC 578-30-5129 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ust be notified at 1 X Yes 2 □ No Director Maryland Prince Georges Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1801 Metzerott Road 20783 United States by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ILIBE TO 11. Marital Status 72 hours after 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 Yes 2 No Specify: injury or other treumatic event, it is Medical Example. 3 Widowed 4 Divorced African American natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked of Be Edgar Jones Willie Mae Quarles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Maurice N. Jones (brother) 5100 New Hampshire Ave. N.W., Wash. D.C. 20011-3210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Mt. Olivet Cemetery 9/2/05 * 4 □ Donation 5 □ Other (Specify) Washington, D.C. 22. Name and Address of Facility McGuire Funeral Service 21. Signature of Funeral Service Licensee hompson 7400 Georgia Ave. N.W., Wash. D.C. 20012 KO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ARRHYTHMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed the burial-transit ACIDOSIC TABOL that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician PERKALEMIA Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate | 2 🗆 No 1 ☐ Yes 1 Yes 2 X No director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 1 Tyes 2 ₹ No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred A:ter Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5 hin 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 ho To the Func (Check only one) 29c. License number 29d. Date, signed (Month, Day, Year) Chandhasethas MD 52855 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20776 7207-B HANOVER PAWY GREENBELT, Md KORAPATI CHANDRA 32 Registrar's Signature State Registrar

			For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment <i>tificate</i>	of H	ealth a Death	ind Me	ental Hy	giezen	05	30267
		10	1. Decedent's Name (First, Middle, Last)						2	. Date of De			3. Time of Death
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}	Examir		4a. Facility Name (If not institution, give s	reet and number)		4b. City, T	own, or	Location of				inty of Deat	
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	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	. last birthday)	If Under 1	Year	If Under 2		Date of Bir (Month, Da		9. Birtl	hplace (State or Foreign
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	P		Usual Residence of Decedent	1						- 0			
	aryla ahov	_	10a. State 10b. County	10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	8a-f	Director	Maryland Montgome	ry	Silve	r Spri	ing						1 ☐ Yes 2X No
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	ath v	rai	4227 Round Hill Ro					0906				SA	
	er de	nne		Was Decedent Ever in L Armed Forces?	J.S. 13. V	Vas Decede f Yes, speci	ent of His by Cubar	spanic Orig n, Mexican,	in? (Speci Puerto Ri	fy Yes or No can, etc.))- 14. F	Race - Amer Black, White	rican Indian, e. etc.
36	thin 72 hours after death with the Maryland e an "natural", or Herns 23a or 28a-f ahow Medical Ezard ner must be notified at	by Funerai	1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give	1	1 ☐ Yes 2	₩ No	Specify:			Spe	cify:	
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0	be filed htal Hygie od other		17. Father's Name (First, Middle, Last)		HOI	шешаке		18. Mother	's Name (First, Middle	Own Maiden Sun		
an		To Be	Francis Kleinsmi	th						elane			
Maryland 21215-0036	should b nd Ment marked imatic e	-	19a. Informant's Name/Relationship (Typ		19b. Mailin	a Address /	Street a	Ann			y e <i>r, Cit</i> y or Toi	wn State 7	Zin Code)
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Ba	permit. Pages 1 Department of H Important: If ite any Injury or ot		11. 56	0	Fra	ancis	J. (Collí	ns Fu	neral	Home,	Inc.	
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			shock, of heart failure. List only one	a cause on each line.			o. c,g	,, 00000		oopiiatory a	iiosi,		Interval Between Onset and Death
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σ,	requires that een signed b nould be deta	by P	Part II. Other significant conditions cont	ributing to death but not res	sulting in the ur	nderlying car	use givei	n in Part I.		23e. Did t	obacco use c	ontribute to	the cause of death?
Records,	w require been sig should b									1 🗆 '	Yes 2⊠No	3 🗀 Pro	obably 4 Unknown
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Vital		0	25. Was case referred to medical					26 Place	of Death /	1 TYes Check only of	2X No	1 🗌 Yes	2LJ No
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Division	ar de recto	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre	et, factory,	office		28	Location (Street and Nu	mber or Rui	ral Route Number,
	spitel or cours afte neral Dir	Certification:	- I resinedo	building, etc. (Speci	·y/					City or To	WII, State)		
	a Hospitel or Atten 24 hours after deat Funeral Director: etely filled in by the	edicai	29a. Certifier 1 Certifying Physi (Check only 2 Medical Examin	cien: To the best of my known: On the basis of examina	owledge, death	occurred at	the time	e, date and	place, and	due to the	cause(s) and	manner as	stated.
	To the Hos within 24 h To the Fur completely	edi	0,107	and manner stated.	ation and/or inv	estigation, i	n my opi	inion, deatr	1 occurred	at the time,	date and plac	a, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	()		29c.	License	number			29d. Date sig	ned (Month	, Day, Year)
•	€6		" LAUSELY	Jusy		18	561-	-DC			August	31, 2	2005
	1		30. Name and address of person who co-	pleted cause of death (le	m 23a) (Type, I	Print)	-						
	_		David J. Perry, M.	D. 110 Irv	ing St	reet,	NW	Was	hingt	on, Do	2001	.0	
	Sta		31. Date filed (Month, Day, Year) SEP 0 1 200	32 Registrar's Sign	ature	well?			_				
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	Physicia		1. Decedent's Name (First, Middle, Las		ISON		2	Date of Death Month AUGUS	Day Year	3. Time of Death
}	/Medic Examin	er	4a. Facility Name (If not institution, give	street and number) ROAD #5		4b. City, Town, or L ANNAPO	slis		4c. County of Deat	runde/
	Funeral Director		416-20-720	ex 7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min. A	Date of Birth (Month, Day, Ye pr. 21,	9. Birti 1933 Mir	hplace (State or Foreign untry) Inesota
	yland now	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Loca	ation				10d. Inside City Limits
	he Mar 8a-1 st	Director	Florida Duval	Jacks	onvil]			100	Citizen of What Co	1 X Yes 2 □ No
	3a or 2	I Di	10e. Street and Number 2970 Shady Drive			10f. Zip Code 32257		US		unitry :
36	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	If \	as Decedent of His res, specify Cuban Yes 2 X No	panic Origin? (Speci , Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Ame Black, White Specify:	
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	e d a b	Be	17. Father's Name (First, Middle, Last) George Andrew Hans				18. Mother's Name (i Dorothy B		· ·	
Maryland	ges 1 and 2 should be filed within to of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Me	ř	19a. Informant's Name/Relationship (Type, Print)	_	Address (Street ar	nd Number or Rural F	Route Number, C	ty or Town, State, 2	Zip Code)
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Balt	permit. Pag Department Important: i any injury o once.	ğ ş	21. Signature of Funeral Service Licer	111	of Facility Cremation	Service	P.O.Box	784 e. MD 21029		
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.O. Box 68760,	The law requires that the death certificate Lite has been signed by the attending physicase 2 should be detached for use as the D	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death	eath 3 🗆 E	ctopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
<u>α</u>	quires that in signed b uld be deta	b	Part II. Other significant conditions of	ontributing to death but not resultin	ng in the und	derlying cause giver	n in Part I.			the cause of death?
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Vital	Physician; this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER	VOutoatient	Other	26. Place of Death (e 6 X ther (Spec	TEMPORARY
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	To the Hospital or Attendwithin 24 hours effer death To the Funeral Director:	Medical (29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	nysician: To the best of my knowle niner: On the basis of examination and manner stated.	edge, death n and/or inve	occurred at the time estigation, in my opi	e, date and place, an inion, death occurred	d due to the caus at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1/		29c. License	_	29d.	Date signed (Monti	h. Day, Year)
1	1		30. Name and address of person who	completed cause of death (Item 2:	(M) () 3a) (Type. P		53306	W.0	8/31/0	15
	186		Cultis Harr	15, mg 900 B	estsa	terd	ste 300	Panap	oolis une	2140
	Sta Regista		31. Date filed (Month, Pay, Year) 2	2005 32. Registrar's Signature	y A	nous				

			For State Registrar	State of Ma	aryland	/ Depa <i>Cer</i>	rtment of tificate o	Healt f Dea	h and M ath	lental Hyg	giene 0	05	30	269
ı	Physicia /Medic		1. Decedent's Name (First, Middle, La Ruth E	11en	Har	desty				2. Date of Dea Month August	Day 26	Year 2005	3. Time o	of Death
	Examin		4a. Fecility Name (If not institution, given Asbury Retirem				4b. City, Town	ns I	sland		4c. County		1	
	uneral irector		5. Social Security Number 218-10-0458 Usual Residence of Decedent	Sex 7. Ag 1 □ M 2 □ X F	e (In yrs. lasi 90	t birthday) Yrs.	If Under 1 Year Months Day		nder 24 Hrs. urs Min.	8. Date of Birt (Month, Da Sept. 1	v, Year)		place (State ntry) yland	or Foreign
at y failed 2.12.13-0030 should be filed within 72 hours after death with the Maryland of Mental Hydiene.	Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic avent, If a Medical Exercit er must be notified at once.	d by Funeral Director	10a. State 10b. County MD Anne An 10e. Street and Number 6224 West Shore 11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced	Drive 12. Was Decedent Armed Forces? 1 Yes 2 1 Yes, Give Year or Dates:	Ever in U.S.	acys	Landing 10f. Zip Code Vas Decedent of Yes, specify Ci	20779 f Hispanic uban, Mex lo <i>Spe</i>	c Origin? (Spe xican, Puerto	ecify Yes or No- Rican, etc.)	Specif	What Cour A ce - Americ ck, White, y: Whi	ean Indian, etc. te	City Limits s 2 ∏ No
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ylarıcı ould be file	arked other	To Be C	17. Father's Name (First, Middle, Last Samuel C. Wood						Agn	es Brad	У			
or Health and	item 27 Is m r other treum		19a. Informant's Name/Relationship (Gilbert L. Hard 20a. Method of Disposition	lesty (Son)	20b. Plac	6224 e of Dispos		hore	Drive	Tracy:		ng, M	D 207	79
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VISION OF VICAL Attending Physicien:	ง: After this certificate งe funeral director, pag	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending investigation		ry 28	/Outpatient 3b. Time of Injury	28c. In	Other:	ursing Ho	n (Check only on me 5 ☐ Resid 28d. Describe h	lence 6 Oth		()	
DIVISIO To the Hospitel or Attend! within 24 hours after death.	To the Funerel Director: completely filled in by the	Certification;	3 Suicide 6 Could not be determined	building, et	c. (Specify)					28f. Location (S City or Tow	m, State)			nber,
the Hosp hin 24 hou	the Fune npletely fil	Medical	(Check only /2 Medical Exa	hysician: To the best miner: On the basis o and manner sta	f examination	dge, death and/or inv	estigation, in m	y opinion,	death occurr	ed at the time, o	date and place,	and due to	the cause(s)
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-516	Sta	ate_	30. Name and addr of person who Toseph Bard 31. Date filed (Month, Day, Year)	TLIO H	ar's Signature	47		3	10 1	Prince	freder	KM	D 210	78
154	Registi		AUG 3 1 200	15 Marines	. K	door	AK I							

Harry Ekas Hasslinger 05-05679 NJM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

December Amount		,,,	í	1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of I		Mental Hy	giene Reg. 2005	30270
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Barrier Barr				4a. Facility Name (If not institution	on, give street and number	r)	4b. City, Town, o	or Location of Death			
Social Brooks Part				1645 Cliff Dr	cive		Mayo			Anne Aru	nde1
The state of the s		Funeral		5. Social Security Number		ge (In yrs. last birthday)			8. Date of Bir		rtholace (State or Foreign
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Mark E. Hasslinger (Son) 1031 01d Bay Ridge Road, Annapolis, MD 21403 20a. Memod of Disposition (Paper of York, State) 20b. Mark E. Hasslinger (Son) 20b. Memod of Disposition (Paper of York, State) 20c. Disposition (Paper of York, State) 20c. Memod of Disposition (Paper of York, State) 20c. Memod of Disposition (Paper of York, State) 20c. Memod of Disposition (Paper of York, State) 20c. Disposition (Paper of York, State) 20c. Memod of Disposition (Paper of York, State) 20c. Memod	lan	ld be ked ked ic ev	O.	Harry L. Hass	linger			Henri	etta Ek	as	
The set of	Ž	shou nd M mar	-	19a. Informant's Name/Relation	ship (Type, Print)	19b. Maili	ng Address (Street	and Number or Rur	al Route Numb	er, City or Town, State,	Zip Code)
Miles Committee Committe	ž	nd 2 alth a 27 ts		Mark E. Hassl	inger (Son)	1031	01d Bay	Ridge Ro	ad, Ann	apolis, MD	21403
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Physician Medical Examiner 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest, internal Between Closed Final Impediate Cause (Final Impediate	H	mit.		21. Signature of Funeral Service	e LjiGnsee		2. Name and Addre	ass of Facility			,
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State Stat	>	hysic lidire	2		Hospital: 1 ☐ Inpa	tient 2 ER/Outpatie	nt 3□ DOA Ott	her: 4 Nursing Ho	ome 5 ☐ Resi	dence 6 CXOther (Sp.	ecity) Scene
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Throw Cocke 10 111 Penn Street Baltimore, Maryland 21201 State 31. Date filed (Month, Day, Year) 32. Resistrar's Signature 12001	ם	ng P Iter ti nera		0	28a. Date of In (Month, D	jury 28b. Time of Injury	of 28c. Inju Wo	ry at ork?	28d. Describe	how injury occurred	
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# Dhysiai		1. Decedent's Name (First, Middle	a, Last)						2. Date of De Month	ath Day	Year	3. Time of Death
Physici /Medic		Mary E				1			ugust	26	2005	2230 ^M
Examin	er	4a. Facility Name (If not institution				4b. City, Town		on of Death			County of Death	
F1		Anne Arundel 5. Social Security Number	Medica.	7. Age (In yrs.		Annapo	ar If Unc	der 24 Hrs.	8. Date of Bir	th	1e Arur	nplace (State or Foreign
- Funeral Director		215-38-0034	1 □ M 25② F	66	Yrs.	Months Da	ys Hour		OV · 1	4 19	Col	vintry) Vland
D >		Usual Residence of Decedent 10a. State 10b. County		10a Cit	ty, Town or Lo	cation						10d. Inside City Limits
shov	ū	,										10d. Inside City Limits 12€ Yes 2 □ No
the h	Director	Maryland Anne 10e. Street and Number	Arunde:	l An	inapo1	1 S 10f. Zip Cod	le			10g. Citi:	zen of What Co	untry?
3a or		9 Rickover c	ourt			2140	1				USA	
death	Funeral	11. Marital Status		cedent Ever in U	.S. 13.	Was Decedent	of Hispanic	Origin? (Spec	ofy Yes or No)-	14. Race - Amer Black, White	
ours after death with the Marylan rel', or Iteme 23a or 28a-f show Executing most by motified at	y Fu	1 Never Married 20 Marr	ned 1 ⊟Yes	2 ⊠No Sive		1 ☐ Yes 2(☐)			, 0.0.,		Specify: B1 a	
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12 sh h and 7 is m traum		19a. Informant's Name/Relations									r Town, State, Z	
Heali Heali tem 2		Thomas R. Hun 20a. Method of Disposition	t (Husba	20b. F	Place of Dispo	sition (Name of	F		DOTIS		cation - City or	21401 Town, State
Pages ent of nt: If It		1 Burial 2 Cremation 4 Donation 5 5 Other (S		n State		matory or other. Crest		9/1/0	05	Anna	polis,	Md.
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nature eny injury or other traumatic event, the Medical Appres.		21. Signature of Funeral Service			2	2. Name and Ad	Idress of Fa	cility				
Dermii Departimoon Impou		Lavy A.	id. P.A.	01								
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deat each line.	th. Do not en	ter the mode of	dying, such	as cardiac or	respiratory a	rrest,		Approximate Interval Between Qnset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	_ a \ /	FNCRE	m	TIS						48 4 2S
/Medical Examiner		resulting in death)	Due to	o (or as a conseq	quence of):							
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atten for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 \sum Yes 2 \overline{\text{N}} \text{No}	1 ☐ Live	birth 2 Feta	al death 3	☐Ectopic pregna ☐ Other (specify				-	Month	Day Year
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gned be det	by P	Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	inderlying cause	given in Pa	art I.				the cause of death?
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g Phy gerthis		27. Manner of Death	28a. Date	e of Injury onth, Day Year)	28b. Time of		njury at Work?		8d. Describe			ary)
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l or Attending after death. Director: After lin by the fune	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 289. Plac	ce of Injury - At hiding, etc. (Special	ome, farm, st	reet, factory, off	ice	2	8f. Location (. City or To			ral Route Number,
pitel o		29a. Certifier (12) Certifyin	an Physician: To the	no hoot of multon	audadaa daal	th annual at the	a time data	and alone a				ata t
Hos 24 hc Fun etely	edical	(Check only 2 Medical one)	ng Physician: To the Examiner: On the and ma	basis of examina inner stated.	ation and/or in	vestigation, in n	ny opinion, o	death occurre	d at the time,	date and	place, and due	to the cause(s)
To the Hospitel or Attending Physicien: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Me	29b. Signature and title of certifie		n	^	29c. Lic	ense numb	er		^	e signed (Month	
		Hanh	1 Na	trons	- In	m I	081	18		100	60ST 3	30 200 5
		30. Name and address of person	who completed ca	use of death (Iter	m 23a) (Type,	Print)	^	A	/A A . I			
5		STANGEY P.	WATLI		ature B)	2816A)	12/10	MINI	צו זטיאוע	N.	2140	7 1
Sta Registr		31. Date filed (Month, Day, Year,	2005	Registrar's Signa	ke de	- 10						

State of Maryland / Department of Health and Mental Hygie 20 0 5 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2^{Day} William Hunt August 2005 11:11A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Nursing & Rehab Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Pay, Year) Aug 9 1928 9. Birthplace (State or Foreign 1√2 M 2□ F Days Hours 579-30-5109 77 Yrs. Director Tennessee Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other then "naturel", or items 23a or 28a-1 show other treumatic event. The Medical Examinar must be notified at Maryland Anne Arundel Annapolis 1X Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 Glenwood St. Apt. 710 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1954-57 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within:
th and Mental Hygiene.
7 is marked other then *r Walter Reed Elementary/Secondary (0-12) College (1-4or 5+) 8th 0 Custodian Medical Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Stafford Pearl Lyles ೭ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s nent of Health an ent: If item 27 is Donald Jackson(Grandson) 246 11th St. N.E. Washington D.C. 20002 20b. Place of Disposition (Name of Mare) Place of Disposition (Name of Disposition) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or 9-2-05 Crownsville, Md. Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Wm. Reese & Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee Larry B. Beese MO648 821 West St. Annapolis, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence_of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as the burial-transit Due to (or as a consequence of): Box 68760, physician certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? þ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed time 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After To the Hospitel or Attending 5 Pending death. investigation 1 Yes 2 No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check of one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 231 ANNAPOLIS, MDZILOI MD RIDGELY AVE STE State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiege 30273 1 - State Registra Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Nancy Jean Girard Harris 25, 10:35a^M Aug. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FutureCare Chesapeake Arnold Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🕱 F Months 64 Director Yrs. <u> 262–14–5538</u> MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No MD Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 or Iteme 23a 305 College Parkway 21012 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after and Mental Hygiene, le marked other than "neturel", or Itel Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify ģ Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 10 **Home** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stephen Girard Jeanette Marquart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s if Health an item 27 le Stephen Bruce Harris/Son 187 Ravens Nest Lane, Cameron, NC 28326 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any Injury or ot Aug. 28, 2005 1 Burial 2 Cremation 3 Removal from State Buffalo Cemetery Sanford, NC * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Service Licenses 495 Gov. ritchie Hwy, Severna Park, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause og each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician tavanceo disease or condition resulting in death) isears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-transit that initiated events resulting in death) Last attending physicien and for use as the burial-trar Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 DNo 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the 9 Unknown 9 Unknown by signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Donknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Uursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 📆 🗸 6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) erans Hwy M. Mersulle MOZINS 30.3Name and address of person who completed cause of death (Item 23a) (Type Riedinger 32. Egistrar's Signature 31. Date filed (Montt State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 30274 For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death SEPTEMBER 2, 2005 **Physician** WILLIAM ZENITH HANSON 2:15 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CARROLL WESTMINSTER NURSING/REHAB CENTER WESTMINSTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUGUST 30, 1924 5. Social Security Number 9. Birthplace (State or Foreign Country) 24 WEST VIRGINIA 6. Sex 7. Age (In yrs. last birthday) Funeral XXM 2□ F Months Days Hours Min Yrs. Director 219-20-0381 81 Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Example must be putified at 1 ☐ Yes 🏋 No Director MARYLAND CARROLL FINKSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21048 UNITED STATES 2960 BLOOM ROAD filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) LINOLEUM MANUFACIURING 8 MACHINE OPERATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event one. MARY VERGIE CROOKSHANKS CHARLES HANSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM L. HANSON/SON 4215 VALLEY VISTA COURT, MANCHESTER, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition XSBurial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) EVERGREEN MEM GARDENS FINKSBURG, MARYLAND 9/8/2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MYERS-DURBORAW FUNERAL HOME, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tou 21157 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) emenha /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that introduced to the conditions) Due to (or as a consequer Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate has 2 🗌 No 1 Yes 2 N 1 Yes Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Derising Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2/11/0 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 28c. Injury at Work? 28d, Describe how injury occurred 27. Manner Death After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 7 Medical (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier X1-181 completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

4

State

Registrar

29b. Signature and title of certifier

32. Regimar's Signature

D-0054218

09-02-2005

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMAN KANERIA M.D.

439 MALCOLM DRIVE, WESTMINSTER, MD 21157

29c. License number

31. Date filed (Month, Day, Year) SEP 0 6 2005

State of Maryland / Department of Health and Mental Hygie 0 5 30275 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year Sandra 10:44PM August 2005 Hawkins /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospital Age (In)rs. last him -cinhain Community DoctoRS (5. Social Security Number 9. Birthplace (State or Foreign Country) 6. Sex If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 F 578-66-1406 Usual Residence of Decedent Director July 27, 1947 the Maryland 10a, State 10b. County 10c. City, Town or Location If item 27 is marked other than "neturel", or Items 23a or 28a-f show or other treumetic event, I're Madical Exerting must be notified at 10d. Inside City Limits Prince George 1 des 2 No Completed by Funeral Director Many And andever 10f. Zip Code 10g. Citizen of What Country? 7938 20785 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 🗆 Yes Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hawkins Sandra Elementary/Secondary (0-12) College (1-4or 5+) Escort 10 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ homas largaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:9 Department of Health ar Importent: If item 27 is any Injury or other treu once. Hawkins/Son Landover Md. 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Aug. 27, 2005 Suitland Md. ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5538 Marlboro PK, Forestville Md, 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only due cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ARDIAL /Medical Due to (or as a consequence of): Examiner Metobs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last hours Examiner Due to (or as a consequence of): physician and s the burial-transit The law requires that the death certificate be executed Sepsi Due to (or as a consequence of): Boute Physician/Medical use as attending 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy been signed by the atte should be detached for Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 1 ☐ Yes 4 □U⊓known 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

or Attending Physicien:

death.

Director:

the funeral

Be

Medicai Certification: To

within 24 hours a To the Funerel [To the Hospitel State Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 01 30. Name and address of person who complet

5 Pending investigation

6 Could not be determined

25. Was case referred to medical examiner?

1 Yes 2 Yo

27. Manner of Death
1 Natural
2 Accident

3 Suicide

29a. Certifier

4 T Homicide

29c. License number 10052865

sin berry Way

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

1 TYes

5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

1 ☐ Yes 2

26. Place of Death (Check only one

Other: 4 Nursing Home

1 ☐ Yes 2 ☐ No

2000

+21

cause of death (Item 23a) (Type, Print)

inpatient

28a. Date of Injury (Month, Day Year)

7202

Hospital:

SEP 0 1 2 2. Registrar's Signature 0 1 2005

DHMH 17 Rev 1/2001

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

3□ DOA

28c. Injury at Work?

	1 - For State Registrar	State of Maryland / Dep Ce	eartment of Health and Mertificate of Death	Mental Hygier	
Physician	Decedent's Name (First, Middle Tour			2. Date of Death	3. Time of Death
/Medical Examiner	Joy 4a. Facility Name (If not institution)	L. Heaster	4b. City, Town, or Location of Death	August 29	9, 2005 9:00 M
Lamine	26170 High Ban		Salisbury		Wicomico
Funeral	5. Social Security Number	6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
Director	214-16-4556 Usual Residence of Decedent	85 Yrs.		9/2/1919	West Virginia
how Last	10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
or 28e-f	Maryland Wico	mico Salisbu			1 Tyes 2 No
3a or		nks Dr.	10f. Zip Code 21801		Citizen of What Country? USA
officer death virilems 23c	11. Marital Status		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
urs after	1 Never Married 2 Marri 3 Widowed 4 Divorced		1 ☐ Yes 2 ▼ No Specify:	Thousan, otoly	Specify: white
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland of other than "natural", or items 23a or 28e-f ehow event, its Medical Evanti artificial at event, the Medical Evanti artificial at Be Completed by Funeral Director		's Education 16a Dec	edent's Usual Occupation	16b.	Kind of Business/Industry
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iled w tygler ther th	12 17. Father's Name (First, Middle, L	<u> </u>	ervisor	H e (First, Middle, Maid	ealth Care
Tey, Mail yildilia x1X13-0030 s 1 and 2 should be filed within 72 hours after death with the Marylan I heetit and Mental Hygiene. If Heetit and Mental Hygiene Talenation of Items 23a or 28a-1 ehow titen 27 is marked other then "natural", or Items 23a or 28a-1 ehow other treumatic event, I'm Medical Evand and marked hours of the To Be Completed by Funeral Director	Charles Elmer		Icie Me		en sumame)
2 should and Men is marke eumatic	19a. Informant's Name/Relationsh		ing Address (Street and Number or Rura		
C, MC	Frances Redden	/friend 615	Sherwood Circle,		
Datiliore, Wi	20a. Method of Disposition 1 Warrial 2 Cremation	3 □Removal from State cemetery, cre	ematory or other place)		Location - City or Town, State
Deficiency permit. Pages Department of importent: if it any injury or o	* 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L	Taraona	JOHN COLL J		lisbury, MD
permi Depai Impo any ir	16th R	Streney CFSP	0110Way Funeral Ho 01 Snow Hill Rd.,	ome Profes Salisbury	sional Association
997	shock, or heart failure. List of	complications that caused the death. Do not en			Approximate Interval Between Onset and Death
Physician / /Medical	Immediate Cause (Final disease or condition resulting in death)	a Auter & schni	to condiava	Jul d	, sour
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To the Hospitel or Attending Physicien: The law requires thet the death certificate be executed within 24 hours alter death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit. Medical Certification: To Be Completed by Physician/Medical Examir	Check only 2 Medical E	Physician: To the best of my knowledge, dea: examiner: On the basis of examination and/or in	th occurred at the time, date and place, a	and due to the cause((s) and manner as stated.
thin 2 the long the l	29b. Signature and title of certifier	and manner stated.	29c. License number		Pate signed (Month, Day, Year)
-31 g	1 Lu	Isey, m	0002567		131100
8-2		who completed cause of death (Item 23a) (Type			
1,0	31. Date filed (Month, Day, Year)	32 Behistrar's Signature	·VINIM AF,	-CULLY V	mm, mc 6 1800
State Registrar	SEP 0	2005 Stoke &	Cast .		

			For State Registrar		Sta	te of M	aryland /	Depa Cer	artment rtificate	of H	ealth a Death	and M	lental Hy	/gieze		5	302	77
			1. Decedent's Nam	ne (First, Midd	de, Last)								2. Date of D	eath			3. Time	of Death
	Physici /Medio		DORIS A	LMA HI	ТСН								AUGUS'	Γ 26		Year 0 05	9:15	P M
7	Examir		4a. Facility Name ((If not institution	on, give street a	and number)			4b. City, 1	own, or	Location	of Death		4c.	County	of Death		
					TER AVE	ENUE			CATO	NSVI	LLE			В	ALT	LMORE	Z .	
	Funeral Director		5. Social Security 1	-3498	6. Sex 1 ☐ M 2]	-	e (In yrs. last	birthday) Yrs.	If Under Months	Year Days	If Under Hours	Min.	8. Date of B (Month, D DEC 2	irth ay, Year) 6, 1 9	914	9. Birthi Coul PA	place (State ntry)	or Foreign
	pue *		Usual Residence of 10a. State	of Decedent 10b. Count	v		10c. City, To	own or Lo	cation							Τ.	10d. Inside (Tity Limite
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Maryland 21215-0036	s i end 2 should be filed within 72 hours after death with the Marylend if Heelth and Mental Hyglene, then "natural", or itama 23a or 28a-f ahow item 27 is marked other than "natural", or itama 23a or 28a-f ahow other traumatic avent. The Madical Examinat must be notilled at	by Funeral Director	11. Marital Status 1 Never Mar 3 Widowed	ried 2□ Ma	12. Wa Am rried 1 [Was Decede	ent of His fy Cubar	spanic Ori n, Mexicar Specify:	i, Puerto	ecify Yes or N Rican, etc.)		14. Rac	k, White,	can Indian, etc.	
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Baltimore,	permit, Pages Department of I Important: if ite any injury or of		1 🔀 Burial 2 ` 4 □ Donation	Cremation 5 Other (I from State	MARYI CEME	LAND LERY	VETER	ANS	U	8/31	/2005			CK, N		
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Divis	0	Certification:	3 Suicide 4 Homicide	6 🗍 Could deten	mined 28e.		ury - At home, c. (Specify)	farm, stre	eet, factory,	office			28f. Location City or To	(Street and own, State,		er or Rura	Il Route Nur	n <i>ber</i> ,
	To the Hospital or within 24 hours effet To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one)	1 Certify 2 Medica	ing Physician: I Examiner: Or an	To the best the basis o d manner sta	t examination	lge, death and/or inv	occurred a restigation,	t the time n my op	e, date an inion, dea	d place, a	and due to the ed at the time	cause(s) date and	and ma place, a	nner as si and due to	tated. the cause(s)
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State of Maryland / Department of Health and Mental Hygie 20 0 5 30278 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 2005 Aug. 24 12:45PM Lizzie K. Henson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 8313 Grandhaven Avenue Upper Marlboro If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2▼F Yrs. Director 579-38-5105 77 3,1928 So.Carolina Jun. Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Items 23s or 28s-f show traumatic avent, the Medical Examiner must be notified at 1 XYes 2 □ No Director Upper Marlboro Md. Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20772 USA 8313 Grandhaven Avenue Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: Be Completed by 3X Widowed 4 □ Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 7 al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Auditor 2 yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental shi: If Item 27 is marked o Mary Ann Williams James L. Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8313 Grandhaven Avenue
Upper Marlboro, Maryland 20772

20b. Place of Disposition (Name of cernetery, crematory or other place)

Date 20c. Location - City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edwina Rollins (Daughter) other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 0 permit. Page Department of Important: If any injury or once. Aug. 31, 2005 * 4 □ Donation 5 □ Other (Specify) Riverdale Crem. Riverdale, Md. 22. Name and Address of Facility
Ralph Williams Funeral Service
1813 PotomacAve., SE; Washington, DC 20003 21. Signaty e of Funeral Service Licensee and Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Failure to thrive (anorexia) disease or condition resulting in death) man the /Medical Due to (or as a consequence of) Examiner scrile dementia Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). death certificate be executed as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physiclan/Medical esn IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 2 X 10 Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide lilled in 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D22780 8/29/2005 ne and addres of person who completed cause of death (Item 23a) (Type, Print) 7500 Greenway Gr Dr. Greenbelt, MD leter m Julistle MD 1 2005 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760.

of Vital Records,

			1 - For State Registrar		of Marylai	nd / Depa	artment of I	Health a		Reg. N		30279			
	Physici		Decedent's Name (First, Mide ALMETA	dle, Last) J.		HU	DТ		Mor	2. Date of Death Month Day Year AUGUST 22,2005 4:40 p M					
	/Medio Examin		4a. Facility Name (If not institution			110		Fown, or Location of Death			4c. County of Death				
			WASHINGTON	ADVENTI	ST HOS	PITAL	TAKOM			М	ONTGOME	ERY CO.			
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🔯 F	7. Age (In yrs		If Under 1 Year Months Days			of Birth hth. Day, Year 06-19	9. Birth	pplace (State or Foreign intry) TER, S.C.			
	Director		578-24-5089 Usual Residence of Decedent			, 113.			03-	00-19	20 SUM	IER, S.C.			
21215-0036	ryland how		10a. State 10b. Count	у	10c. C	ity, Town or Lo	cation					10d. Inside City Limits			
	Ba-1 s	cto	DC		W	ASHING	TON		_			1 Yes 2 No			
	with th	Dire	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Cou	intry?			
	eath ve 234	erai	461 H STRE		517 sedent Ever in U	I C 12 1	2000 Was Decedent of h		igin? (Chaoite Va		U.S.A.	ion Indian			
	fter dea	Funeral Director	1 Never Married 2 Ma	Armed F rried 1 ☐ Yes	orces? 27∑No	7.3.	f Yes, specify Cub	an, Mexicar	n, Puerto Rican, e	itc.)	Black, White				
	72 hours after death with the Maryland natural', or items 23a or 28a-1 show disal Exart mar must be indified at	i by	3 Widowed 4 ☐ Divorce	IT YAS (i	ive		I□Yes 2☐XNo	Specify:			Specify: BI	ACK			
5-0	172 hours after death with the Marylan "naturat", or items 23a or 28a-1 show idjoal Exan't et mast be indilled at	Completed	15. Decede (Specify only high	nt's Education est grade completed)		(Give	lent's Usual Occup kind of work done	during mos	t of working	16b. l	Kind of Business/li	ndustry			
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	Hygint, Ind.	Be Co	12th 17. Father's Name (First, Middle	, Last)				18. Mothe	er's Name (First,						
Maryland		To B	HENRY	J	EFFERS	ON			UNKNOW	N					
lary	and and and and		19a. Informant's Name/Relation								or Town, State, Zi	· · · · · · · · · · · · · · · · · · ·			
	s 1 and 2 if Health item 27 i		TYRONE HURT	- SON	205			ET, 1		-	. DC 20				
lore			20a. Method of Disposition 1 ☐ Burial 2√☐ Cremation 4 ☐ Donation 5 ☐ Other (3 □Removal from	State	cemetery, cren	sition (Name of natory or other pla	1	Date	1.00	ocation - City or T				
Baltimore,			21. Signature of Funeral-Service	CONTRACTOR OF THE	RI		LE PARK . Name and Addre				RIVERDA				
Ba	permit. Departr importa any inje		1/50	Do. 0	6)	11			111110		UNERAL NW WASH				
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that	caused the dea	th. Do not ente	er the mode of dying	ng, such as	cardiac or respira	atory arrest,	ZIW WZIBII	Approximate Interval Between			
	Physician	Immediate Cause (Final disease or condition CARDIORESPIRATORY FAILURE									Onset and Death				
	/Medical Examiner		resulting in death)		(or as a consec	quence of):									
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	U	b. SEPSIS Due to (or as a consequence of).										
	cuted	that initiated events		UTI	c UTI/ ASPIRATION PNEUMONIA										
, 00,	e exercian ar	Ex	resulting in death) Last	Due to	Due to (or as a consequence of):										
58760,	icate be executed physician and s the burial-transit	edical		d											
_		ician/Me	ician/Me	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	23c. If yes, outcome of pregnancy						23d. Date of delivery		
. Box	death e atter				in the past 1 X months?		Ectopic pregnancy Other (specify)	У			Month Day Year				
P.0	at the de by the a stached	hys	9 🗆 Unknown	9□ Unkr											
	law requires that the death certif as been signed by the attending 2 should be detached for use a	by	Part II. Other significant condit					en in Part I.	. 23e			he cause of death?			
orc	w require been sk should t	eted	CHRONIC OF	STUCTIVI	E LUNG	DISEA	ASE			1 Yes 2	:	bably 4 XUnknown			
Vital Records,	0 - 0	ompieted							24a	. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of			
tal		e Co	25. Was case referred to medic	al le				OC Bloom	of Death (Check	performed? Yes 2 No	1 ☐ Yes	2 X No			
τVi	Physiclan: this certific ral director,	O B	examiner? 1 ☐ Yes 2 🛣 No		Inpatient 2	ER/Outpatien	t 3□ DOA Oth				6 ☐Other (Special	fv)			
n of		L:uo	27. Manner of Death 1 ☑ Natural 5 ☐ Pend	28a. Date		28b. Time of Injury	28c. Injur Wor	y at	28d. Des	scribe how inju	iry occurred	,,			
sio	Attending or death. ector: After by the fune	catle		igation			M 1	Yes 2 1							
Division		ertification;	4 Homicide deten	nined 286. Place	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						nd Number or Run e)	al Route Number,			
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	O	29a. Certifier 17 Certify	ng Physician: To the	e best of my kno	owiedge, death	occurred at the tir	ne, date and	d place, and due	to the cause(s	s) and manner as s	tated.			
	To the He within 24 To the Fu	ledical			asis of examina iner stated.	ation and/or inv	estigation, in my o	pinion, deat	th occurred at the	time, date an	d place, and due to	o the cause(s)			
	To with	Σ	29b. Signature and title of certifi	er			29c. Licens			29d. Da	ite signed (Month,	Day, Year)			
^		- 3	30 Name and address of account	who completed	on of don't /l	m 22a) (T	609	99		AUG	GUST 29	, 2005			
1			30. Name and address of person DR • ARUNA	PASPULA	- 106	IRVINO	G ST.,	NW # 4	415 WAS	HINGT	ON, DC	20010			
	Sta		31. Date filed (Month, Day, Year) 3 4 . F	Registrar's Signa	ature									
	Registr	ar	AUG 3 1	ZUUD 27/2	PILLE A	100									

State of Maryland / Department of Health and Mental Hygie 0051 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Harry Reamshart Hursh, II 2005 1204 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 207 Schmechel Street Harford Aberdeen | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Apr. 11, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1X M 2□ F Director 169-44-6058 52 Yrs 1953Pennsylvania Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10h Counts 10d. Inside City Limits ral', or Items 23a or 28a-f ebov Example: must be coliffed at 1XXYes 2 □ No Director Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 207 Schmechel Street 21001 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No I Yes, Give Year or Dates: 1976–86 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Iten any injury or other traumatic event, the Medical Example 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Civil service U.S. Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Reamshart Hursh Helen Bittinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 Schmechel St. Therese Hursh (Spouse) Aberdeen, MD 21001 more, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) 9/8/05 R. A. Ferris & Co. West Chester, PA 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hangen /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of): physician Box 68760 Physiclan/Medlcal IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? for 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No Jas autopsy performed' certificate 2 🙀 № To the Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 Nursing Home 5 X Residence 6 □Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 🗷 No investigation 4 2005 1204PM 2 Accident Diractor: 6 Could not be determined e. Place if Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Lo., tion (Street of Number or Rural Route Number, Cir. or Town, Stale) 4 Homicide within 24 hours aft To the Funeral Di completely filled in ai romo 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person to completed cause of death (Item 23a) (Type, Print) MU DME 32. Redistrar's Signature State 2005 Registrar

05-05656 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Gloria Jean Geddie Amend Item 1 per ME, G861, 11/03/06dhb 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Gloria Jean Geddie Day Year Month **Physician** Geddie Gloria Jean 21, 2005 0856 A. August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14328 Colonel Claggett Court Upper Marlboro Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

(Month, Day, Year)

July 7, 1957 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 2 🖾 F 578-80-5188 WashingtonDC Yrs. Director Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits al Hygiene. other then "naturel", or iteme 23e or 28e-f ehow vent, the Medical Exeminar must be notified at 1 Yes 2 No Prince George's Upper Marlboro Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 14328 Colonel Claggett Ct 20772 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) EMA Specialist 12 Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be Department of Health and Mental Important: If item 27 is marked eny injury or other traumatic events. and Mental la marked Calvin Kirby Shirley Haskell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Geddie /Husband 14328 Colonel Claggett Ct Upper Marlboro MD 20772 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Glenwood Cemetery 8-27-05 Washington DC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pope Funeral Home 2617 Fenn Ave SE Washington DC 20020 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Smoke inhalation and thermal injuries **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ysicien and the burial-transit the death certificate be executed Due to (or as a consequence of): Physician/Medical the as attending for use as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 1. ↑ Yes 2 □ No 24a. Was an certificate 1 Yes 2 No director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑Other (Specify) (Scene) ٩ 1XX Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28b. Time of Injury 28d. Describe how injury occurred subject mud ved 28a. Date of Injury (Month, Day Year) 27 Manner of Death Certification: 1 Natural
2 Accident
3 Suicide 5 Pending investigation in house fire 1 Yes 2 No death. 7:53 8/21/05 Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 14328 Colonel Claggett 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hours efter seene Court upper Morthon, mo within 24 hours of To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

And manner as stated.

And manner stated. 29a. Certifier

31. Date filed (Month, Day, Year) State Registrar

cause of death (Item 23a) (Type, Print) Pamela E. Souther mn

29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E. August 22, 2005

111 Penn Street, Baltimore Maryland 21201

32. Registrar's Signature

29b. Signature and title of certifier

			riease	Chata of Manua				-	_	•			
			1 - State Registrar	State of Maryla		artment of F tificate of		Mental Hy	gie 2005	30282			
	Physici	an	1. Decedent's Name (First, Middle, L.	ast)	-	11		2. Date of De	eath Day Yea	3. Time of Death A			
1	/Media	al	DEVN12		<u> </u>	SYNE	5	August		0			
	Examir	er	4a Facility Name (If not institution, gi	1 01 1	nter	4b. City, Town. o	or Location of Dear	h	4c. County of De	eath_ U.C.D			
	Funeral			Sex, 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bir	th 9. E	Birthplace (State or Foreign Country)			
	Director		213~ 70~ 8500 Usual Residence of Decedent	1 X M 2□F	18 Yrs.	Working	Tiours Will	(Month, Da	3-57 M	ARYLAND			
	yland how		10a. State 10b. County	10c.	City, Town or Lo	cation	_			10d. Inside City Limits			
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23a or 28a-f show other traumatic event, the Medical Examinal must be notified at	Completed by Funeral Director	Md Some	rset t	rinc		anne	•		1 X Yes 2 □ No			
	3a or 3	I D	12486 Love:++	a Road.		2185	53		10g. Citizen of What	Country?			
	deatl	ner	11. Marital Status	12 Was Decedent Eyer in	U.S. 13.	Was Decedent of H f Yes, specify Cuba		Specify Yes or No	- 14. Race - Ar	n <i>e</i> ncan Indian,			
36	or ite	y Fu	1 Never Married 2 Married	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Tes, specify Cuba	Specify:	to Hican, etc.)	Black, W Specify:	hite, etc.			
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ind	be file	Be	17. Father's Name (First, Middle, Las			J	1		, Maiden Sumame)	J			
Maryland	should be nd Mental marked c	2	Herschel 19a. Informant's Name/Relationship	V. JOYN		a Addross /Street		NNE	Thom				
Ma	nd 2 sho Ith and 27 is mu r traum		Cherule Joh	nexal (sister		Suffolk			er, City or Town, State Y, MOL 2				
re,	of Health of Health fitem 27 r other tr		20a. Method of Disposition		D. Place of Dispo			Date	20c. Location - City				
altimore	Pag nent ant: i		1 Burial 2 □ Cremation 3 (4 □ Donation 5 □ Other (Spec	Removal from State	•	ley unc c	· · · · · · · · · · · · · · · · · · ·	3-05	Marok	in, md			
Balti	perriit. Page Depirtment o Important: if any injury or once.		2 Signal of Funeral Service Lice	nsee	22	Name and Addre	ss of Facility		Esabella				
	<u></u>		My Sea		FL	Neral H	OME		oury, Md a				
	hysician /Medical Examiner		23a. Part1. ENd the disease, or cor shock, or leart failure. List only Immediate Cause (Final	the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator eart failure. List only one cause on each line. FUL MINANT HEPATIC FAILURE						Approximate Interval Between Onset and Death			
			disease or condition resulting in death)	a. Due to (or as a cons		1 2 weeks							
			On the Park of the	ALCOHOLIC CIRRHOSIS LIVER						34EARS			
-	p =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons		14.1							
	le be executed ysician and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
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)			30. Name and address of person who M. SHIRAZI, M.			Print)			p. MD 2				
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	Registr	ar	31. Date filed (Month, Day, Year) SEP 0 1	2005 Stewa	I A	all .							

State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 2:25 September 8, 2005 Robert Lee Jackson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayside Care Center Lexington Park St. Mary's If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 € M 2 □ F 82 Nov 25, 1922 Director 577-24-0709 Washington, D.C. Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County r then "natural", or items 23a or 28e-f ehow the Medical Expirings must be collified at 1 ☐ Yes 2 ☑ No Directo Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23202 Woodland Acres Road Funeral 20619 ' USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 √ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specity: Specify: White þ 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Plumber U. S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jet, Maryla.

Jermit. Pages 1 and 2 should be 1.

Department of Health and Merimportant: If them 27 to eny injury or consequence. Richard E. Jackson Ada Cecelia Dean 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James Brian Jackson/Son 23202 Woodland Acres Road, California, Maryland 20619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sep 13,2005 | Hollywood, Maryland St. John's Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A., 21. Signature of Funeral Service Linens P. O. Box 270, Leonardtown, Maryland 20650 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a Part1 mediate Cause (Final **Physician** Carcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tra-Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9□ Unknown 9 Unknown s been signed by the should be detached Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 2 PRO 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel o within 24 hours aff To the Funeral Di Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19917 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. James C. Boyd, Wildewood Shopping Center, California, MD 31. Date filed (Month, Day, Yea State 2005 Registrar

DHMH 17 Rev 1/2001

Amend item#5, perFH, G847, 9723/05 TT State of Maryland / Department of Health and Mental Hygiene 0 5 1 - For State Registrar 30284 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** AUGUST 2005 8:45 PM HELEN. JACKSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. 1 ☐ M 2 🖾 F Yrs. 91 SOUTH CAROLINA JUNE 8 1914 Usual Residence of Decedent 10a. Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Director PRINCE GEORGE'S LARGO. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 NORTH HARRY TRUMAN DRIVE # 403 U.S.A. 500 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 X No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: ð 3 XWidowed 4 □ Divorced BLACK Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FOSTER GRANDPARENT GOVERNMENT 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MARY FERGUSON CHEEK HERBERT 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 19a. Informant's Name/Relationship (Type, Print) 18241 LOST KNIFE CIRCLE # 201 MONTGOMERY VILLAGE, MD HOWARD/NIECE EDA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) RIVERDALE CREMATORY! 9/3/05 RIVERDALE, MARYLAND 21. Signature of Edneral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC ARREST disease or condition resulting in death) Due to (or as a consequence of): CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine HYPERTENSION that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERCHOLESTEREMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an mea? 2 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 2 ER/Outpatient 2 1 Inpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner certificate be executed Division of Vital Records, P.O. Box 68760. Hospital or Attending Physicien:

Funeral

Director

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Items 23e death

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 Is marked other then "natural", or Iter

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29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

Baltimore, Maryland 21215-0036

traumatic event, the Madical Examiner must be nutified at

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State

29c. License number

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

20774

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1221 Mercantile Lane Largo, Maryland J.W. McConnell M.D.

31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 3 1 2005

State of Maryland / Department of Health and Mental Hygiege Reg. 2005 1 - For State Registrer Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** DAVID FREEMAN JOHNSON AUGUST 28 2005 1706 р /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL PRINCE GEORGE'S CLINTON If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months IX M 2 □ F Director 80 28, 1925 Tennessee JAN. 210 18 4912 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b Counts 28e-f show other traumetic avent, if e Medical Examiner must be nutilised at 1 ☐ Yes 2 ☐ No Director Maryland Prince George's Camp Springs 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 6706 Edgemere Drive 20748 USA or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hyglene. Is marked other than "natural", or Iter 1 Never Married 2 Married ☐Yes 2X No f Yes, Give 1 ☐ Yes 2 ☐ N/O Baltimore, Maryland 21215-0036 Specify: Specify: þ Black. 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Biochemist Government 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) David F. Johnson Coma (unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 Is m any injury or othar traum once. Gloria Johnson / wife 6706 Edgemere Drive Camp Springs, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) Lincoln Cemetery 9-3-2005 Suitland, 22. Name and Address of Facility Marshall's Funeral Home of MD 21. Signature of Funeral Service Licensee 10m 4308 Suitland Road Suitland, MD 20746 23a. Parf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a.ATHEROSCLEROTIC HYPERTENSIVE /Medical Due to (or as a consequence of): Examiner CARDIOVASCULAR YRS DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a consequence of: Examine the attending physician and hed for use as the burial-transit certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 5 Other (specify) 4 Pregnant at time of death þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown CORONARY ARTERY DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an CARCINOMA OFTHE LUNG 2 No JEPENDENT 1 Yes RENAL FAILURE DIAL YSIS 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient 1√ Yes 2 No Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Attending 1 Natural 5 Pending after death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To tha I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0016116 2912 August 2005 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAMELA ROAD PISCATAWAY # 750 CLINTON 31. Date filed (Month, Day, Year) Registrar's Signature State SEP 0 1 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 05 30286 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 31 2005 **Physician** Hampton Lorenzo Kellam Sr. Aug. 0226 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Peninsula Regional Medical Center Salisbury If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Aug. 23. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1924 Virginia 10XM 20 F 81 229-38-7592 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County ral', or items 23a or 28a-f shov 1 Yes 2 No Directo Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21801 U.S.A 900 Mohawk Avenue Funerai 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates "natural', Completed 15. Decedent's Education (Specify only highest grade completed) 27 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lucretia Sturgis Joseph Kellam Sr. ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Kellam (Daughter) 725 Richmond Ave. Salisbury, Md. 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Salisbury Crematory Salisbury, Md. * 4 ☐ Donation 5 ☐ Other (Specify) Stewart Funeral Home 821 West Road Salisbury, Md. 21801 21. Signature of Funeral Service Licenses Bladys 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) Yes 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 3 Probably 4 Whiknown 1 TYes 2 No been : 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 2 No 1 Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After ivision 1 Natural 5 Pending investigation М death. 1 Yes 2 No 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 THomicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and Mile dertifier 29c License number 29d. Date signed (Month, Dav. Year) 7331 completed cause of death (Item 23a) (Type, Print) 30. Name and

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day)

P.O. Box 68760.

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Exa	mine		4a. Facility Name (If not institution, give street and number) 216 Belview Ave.				Hagerst			4c. County of Washin	gton
Fune Direct			218-24-1342	7. Age	9 (In yrs. Ia 76	est birthday) Yrs.	Months Day		Min. (Month. Da	2, 1929 M	Birthplace (State or Foreign Country) aryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "raturel", or Items 23e or 28a-f show entry injury or other traumatic event, I'm Medical Evaniner must be notified at ance.			Usual Residence of Decedent 10a. State 10b. County MD Washingto			Town or Loc					10d. Inside City Limits 1 🔀 Yes 2 🗀 No
vith the M or 28a-f	i de la		10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	
72 hours after death with the Maryland naturel; or Items 23e or 28a-f show lost a few maturel.		nuera	216 Belview Ave. 11. Marital Status 1 Never Married 2 Married	. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N				f Hispanic Origin uban, Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)	U.S.A.	American Indian, White, etc.
72 hours at naturel; or	1	2	3 XWidowed 4 □ Divorced 15. Decedent's Education	If Yes, Give Year or Dates:	1	16a. Deced	☐ Yes 2 🗓 N	upation	working	Specify:	White ness/Industry
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yidild ould be file Mental Hy arked oth	0	lo Be	17. Father's Name (First, Middle, Last) Russell D. Anderson	n					Name (First, Middle A (Unknov		
and 2 should is all and Men and 27 is marke			19a. Informant's Name/Relationship (<i>Type</i>) Patti A. Petty/Dau				•		r Rural Route Numb agerstown	per, City or Town, Sta , MD 2174	
mit. Pages 1 a partment of Heap portant: If item viniury or other			20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	- 1		sition (Name of patory or other pen		Date 7/2005	20c. Location - Cit	
Definit. Departm	once.		21. Signature of Funeral Service Licensee Signature of Funeral Service Licensee	na						n Funeral agerstown	
Physici /Medio Examir	al		23a. Part1. Enter the disease, or complio shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	s that caused se on each lin	cer	noid	er the mode of d	ying, such as car	a pp	arrest, Md(X	Approximate Interval Between Onset and Death One Man Man
ficate be executed physician and steep by the burial transit		edical Examiner	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as							
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g-		2	Part II. Dther significant conditions cont	nbuting to death b	ut not resu	Iting in the ur	derlying cause	given in Part I.	23e. Did	\ \ /	ute to the cause of death? Probably 4 □Unknown
	5	Completed							1 ☐ Yes	priormed? priormed? dea	re autopsy findings available in to completion of cause of th?
ling Phys		ation; To Be	25. Was case referred to medical examiner? Yes No	ent 2 🗆 t ry y Year)	ER/Outpatient 28b. Time of Injury	28c. In	26. Place of Death (Check only one) Wher: 4 \(\text{ Nursing Home} \) 5 \(\text{ Residence} \) 6 \(\text{ ther (Specify)} \) 4 \(\text{ Nursing Home} \) 10 \(\text{ Secribe how injury occurred} \) 10 \(\text{ ord } \) 10 \(\text{ Nursing Home} \) 10 \(\text{ Secribe how injury occurred} \) 11 \(\text{ ord } \) 12 \(\text{ Nursing Home} \) 13 \(\text{ Secribe how injury occurred} \) 13 \(\text{ ord } \) 13 \(\text{ Nursing Home} \) 13 \(\text{ Secribe how injury occurred} \) 14 \(\text{ Nursing Home} \) 15 \(\text{ Secribe how injury occurred} \) 15 \(\text{ Nursing Home} \) 15 \(\text{ Secribe how injury occurred} \) 15 \(\text{ Nursing Home} \) 15 \(\text{ Secribe how injury occurred} \) 15 \(\text{ Nursing Home} \) 15 \(\text{ Nursing Home} \) 15 \(\text{ Secribe how injury occurred} \) 15 \(\text{ Nursing Home} \) 15 \(Nursing H				
pital or Attendi ours after death. lerel Director: A		Certification:	3 Suicide 4 Homicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								or Rural Route Number,
To the Hospital within 24 hours of To the Funerel I		edical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	cian: To the best er: On the basis of and manner sta	f examinat	wledge, death ion and/or inv	occurred at the estigation, in m	time, date and p y opinion, death o	elace, and due to the occurred at the time,	cause(s) and mann date and place, and	er as stated. I due to the cause(s)
To the I within 2 To the I		M	29b. Signature and title of certifier		_	m	29c. Lice	DHL L	+ 43	29d. Date signed (/	Month, Day, Year)
11-3			30. Name and address of person who con	npleted cause of d	death (Item	23a) (Type,	Print)	30 0	OPAL	CT, He	21740 m
Por	Stat		31. Date filed (Month, Day, Year) SEP 0 7 20	32. Registr	ar's Signat	ture 1	a. M.			1	J

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 005

				,	Certifica	te of Death	1	Re	a. K. UU5) 3	30288	
4	Physician	1. Decedent's Name (First, Middle, L Edith Ruth Kight	ast)					ate of Death	5 Day 200		3. Time of Death 8:00 PM	Ī
	/Medical Examiner	4a Facility Name (If not institution, ga Julia Manor Heal		•	own, or Location	n of Death	th 4c. County of Death Washington					
	Funeral Director	220-16-3230		(In yrs. lest bii 90	Yrs. If Und	Min. (/	Pate of Birth Month, Day, 119/19	Year) 15	. Birthpla Country	ce (State or Foreign y) MD		
	Marylend If show If a show If a show	Usual Residence of Decedent 10a. State 10b. County MD Washin		10c. City, Tow Hagers						100	d. Inside City Limits 1 ☑ Yes 2 ☐ No	
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiane. mportant: if them 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Madical Examinar must be noritied.	th with the 23e or 28 is the nor all Direct	10e. Street and Number 1330 Potomac Ave	., Apt. 24B		10f. 2	ip Code 21740		10	g. Citizen of Wha	at Country	γ?	
	uid be filed within 72 hours after death with the Mar Maral Hygians and tural; or fems 23a or 28a-f s rite event, the Medical Examinat must be nortified To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto I				ecity Yes or No- Rican, etc.) 14. Race - American Indi Black, White, etc. Specify: White			c.	
	within 72 ho ane. Ithan "natur in Madical impleted	15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+)				ual Occupation vork done during mos use retired) Les Clerk	st of working	11	16b. Kind of Business/Industry Clothing Retail			
and 2	ould be filed y Mental Hygia arked other i atic event, tr	17. Father's Name (First, Middle, Las Henry (unk) Chan	18. Moth	8. Mother's Name (First, Middle, Maiden Surname) Bertha (unk)								
کا	should and Men amerka umetic	19a. Informant's Name/Relationship	•	195	. Mailing Addre	ss (Street and Numb			City or Town, Sta	ate, Zip C	code)	
Ĕ	and 2	Peggy J. Duffey/	Daughter	14	4 Carria	age Hill D	Drive, H	Hagers	town, M	217	742	
more	Pages 1 and the nent of He ant: If Item ury or other	20a. Method of Disposition 1 \text{\text{\text{Spurial}}} 2 \text{\text{\text{Cremation}}} 3 \text{\text{\text{Removal from State}}} \ 20b. Place of Disposition (Name of cemetery, crematory or other place)} Rose Hill Cemetery 20c. Location - City or Town, State 20c. Location - City or Town, State										
Balt	pemit. Page Depertment of important: if any injury or once.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral H. 305 N. Potomac Street, Hagerstown, MD 21740									al Home 21740	
	Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Ī
4	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a consequence of: Abdominal metastesis							_		
	je je		h	00 10 (01 00 0	/	Abdomi	nal	met	:Tastesis			
•	ficeta be executed sphysician end ts tha bunel-trensit edical Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	consequence of									
68760,	a be e sician a burie cal E	I that initiated events	consequence of)•				-		_		
Box 68	aath certificeta be executed attanding physician end for usa as tha buriel-trensit clan/Medical Examir	resulting in death) Last	0011004401100	,			İ					
Ď	daath e atta ed for sicia	Part II. Other eignificant conditions	contributing to death but	not resulting in	n the underlying	cause given in Part	1.	23b. Did tob	acco use contri	bute to t	he cause of death?	_
s, P.O	w requires that the daath ce been signed by the attand should be detached for us, leted by Physician/	14 y pertension						1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unk			bly 4 Unknown	ı
Division of Vital Records,	E 8 8 0							24a. Was an performe		avail	e autopsy findings able prior to pletion of cause ath?	
r =	The sate has page							1LI Yes	3410	10	Yes 2□ No	
VIT S	clan: artific actor, Be	25. Was case referred to medical examiner?	Hospital:			0.1	e of Death (Ch					
0	Physic this can al dire	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatient	2 🗆 ER/Ou		JUA 41ETNI			nce 6 DOther ((Specify)		-
0	th. : After a fune	1 □Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Y	a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 ☐ Yes 2 ☐ No				28d. Describe how injury occurred				
DIVISION OF VITAL HE IN TO THE HOSPITAL TO THE PROPERTY TO THE PROPERTY AFFORM TO THE FUNCTOR Affor This cardificate has completely filled in by the funeral director.	Ital or Attending P ins after death. al Director: After t led in by tha funera Certification:	3 Suicide 6 Could not determined	/ - At home, fa (Specify)	arm, street, factory, office 28f. Location City or T			ocation (Stre City or Town,	(Street and Number or Rurel Route Number, own, State)				
	To the Hospital can within 24 hours at To the Funeral D completely filled i	29a. Certifier 1 Certifying P (Check only one) 2 Medicai Exa	hysician: To the best of miner: On the basis of end manner state	xamination en	e, death occurre ad/or investigation	d at the time, date er n, in my opinion, dea	nd place, and d ath occurred at	ue to the ceu the time, dat	use(s) and manne te and place, and	er as stat I due to th	ed. ne cause(s)	
	vithir To th comp	29b. Signature and title of certifier	29c, License number 90060396				29d. Date signed (Month, Day, Year)					
		30. Name and address of person who	completed cause of dea	th (Item 23e)	(Type, Print)				-//			_
ÞΗ	-3	Farid Murshed, 1			agersto	vn, MD 217	740					_
Sale	State	31. Date filed (MonSEP Year)	2005 32. Fegistrar's	s Signature	1.1	,						

		-	For Stata Registrar	State of	Marylan		artment of H rtificate of I		Mental Hy	giene Reg. No.	005	30289
Ph	ysicia	n	1. Decedent's Name (First, Middle, L	•					2. Date of D Month	Day	Year	3. Time of Death
//\	Medic	al -	Joseph 4a. Facility Name (If not institution, g.		John		KOPYTA	Location of Deati	Septem		County of De	9
Ex	amin	er	Washington Count				Hagerst				SHINGT	
Fun	eral			Sex	7. Age (In yrs. i		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	irfh	9. Bi	rthplace (State or Foreign country)
Dire	ctor	-	148-03-8606 Usual Residence of Decedent	1 M 2□F	88	Yrs.			Jun.30),191	7 Nev	v Jeresy
yland	74		10a. State 10b. County			y, Town or Lo						10d. Inside City Limits
e Mar	Millipod	ctor	MD Washin	gton	Wi	Iliams	port					1 Ves 2 No
with th	De no	Funeral Director	10e. Street and Number				10f. Zip Code				zen of What C	Country?
leath y	must	eral	20 Springfield 11. Marital Status	12. Was Dece	dent Ever in U.	S. 13. \	21795 Was Decedent of H	ispanic Origin? (S	pecify Yes or N		SA 14. Race - Am	erican Indian,
after o	Titrier	Fun	1 Never Married 2 Married	Armed For	2 🗆 No	'	f Yes, specify Cuba	in, Mexican, Puert Specify:	o Rican, etc.)		Black, Wh	ite, etc.
nours urel;	Exa	d by	3 Widowed 4 Divorced		e WWII		1 ☐ Yes 2 No			, .		Vhite
in 72 i	le III	olete	15. Decedent's (Specify only highest g	rade completed)		(Give	tent's Usual Occup kind of work done o DO NOT use retired	durina most of wor	rking	16b. Kir	nd of Busines:	s/Industry
d with giene.	The A	Completed	Elementary/Secondary (0-12)	College (1-	-4or 5+)	Su	pervisor			Tru	uck Mar	nufacture
III. Z I Z I 3-0030 be filed within 72 hours after death with the Maryland ital Hygiene. d other then "neturel", or Items 23a or 28a-f show	event	Be	17. Father's Name (First, Middle, Las					18. Mother's Nar		e, Maiden .	,	
y la nould d Men narke	natic	2	John 19a, Informant's Name/Relationship	Martin		Kopy†	a Address (Street	Fran		has City of		Pankiewicz
INICAL Ith an 27 Is r	rtreur		Phyllis L. Kopyta				pringfiel					
s 1 ar of Hea item	other		20a. Method of Disposition			lace of Dispo	sition (Name of matory or other place		Date	•	cation - City o	
partition (c), Interpretation 2.12.13.7000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "neturel", or Items 23a or 28a-f show	ury or		1 ☐ Burial 2 🛣 Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec	cify)	State	thsburg	Crematory	Sep.5	,2005	Smit	hsburg	, MD 21783
ermit.	any inj		21. Signature of Soneral Service by		1	0 0	. Name and Addres	ss of Facility JNERAL HO	ME			
0.05	45 CX	-	23a. Part1. Enter the disease, or co	mplications that co	used the death	4	<u> 25 S. Cor</u>	nococheac	ue St.		iamspor	+, MD 21795
Dhuni			shock, or heart failure. List onlinediate cause (Final	y one cause on ea	ach line.		,		or respiratory t	arrost,		Onset and Death
Physic /Med	lical		disease of condition resulting in death)	aDue to (or as a consequ	uence of):	neart bl	i CIC				2 years
Exam			Sequentially list conditions,	b. Coro	nary	artor	y disea	se				years
pe	ısıt	lne	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a consequ	uence of):	U					0
sxecut n and	al-trar	Examlner	that initiated events resulting in death) Last	c. N 70 0	or as a consequ	uence of):	à	***************************************				years
cate be executed physician and	the burial-transit	dical		d								
artifica ing ph	e as th	Med	IF FEMALE:									
box eath cer attendir	for us	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?		come of pregna irth 2 ☐ Fetal ant at time of de	Jdeath 3 ☐	Ectopic pregnancy Other (specify)			2	3d. Date of de Month	olivery Day Year
the dy	ached	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno		Jun 3	Ottlet (apacity)					
Physicien: The law requires that the death certificate has been signed by the attending	se det	by P	Part II. Other significant conditions	contributing to de	ath but not resu	ulting in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco us	se contribute t	to the cause of death?
law requires tas been signer	plno		hypertension						1 🗆	Yes 2	QNo 3□P	robably 4 Unknown
e law has b	le 2 sh	Completed							24a. Was		24b. Were a prior to death?	utopsy findings available completion of cause of
ricien: Th	or, pag	e Co	25. Was case referred to medical					OC Plans of Pass	1 ☐ Yes	2 10	1 □ Ye	
ysicie ysicie	directo	To Be	examiner?	Hospital:	npatient 💥	ER/Outpatien	t 3 DOA Oth	26. Place of Dea er: 4 ☐ Nursing H	lome 5 ☐ Res		Other (Spe	ecify)
ng Phy Iter this	neral		27. Manner of Death 1 Statural 5 ☐ Pending	28a. Date o	of Injury h, Day Year)	28b. Time of Injury	28c. Injun Worl		28d. Describe			
lor Attending after death. Director: Afte	the fu	catle	2 Accident investigati	be	(1)			Yes 2 □No	201	(0)	/ ht	
or At after of Direc	in by	Certification;	4 Homicide determine	28e. Place	of Injury - At no ng, etc. (Specif)	ome, tarm, str	eet, factory, office			(Street and own, State)	i Number or H	lural Route Number,
To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending p	y filled		29a. Certifier 1 Certifying I	hysician: To the	best of my kno	wledge, death	occurred at the tin	ne, date and place	, and due to the	cause(s)	and manner a	s stated.
the Ho in 24 the Fu	pletel	ledical	one)	aminer: On the ba and mann	er stated.	tion and/or inv	vestigation, in my o		rred at the time,			
To To To	СОП	Σ	29b. Signature and title of certifier				29c. License				_	th, Day, Year)
			30. Name and address of person wh	o completed caus	a of death /Itom	23a) (Type	D 0 05	8/45		spre	morr	4,2005
4-4+1			Tu T. Bui, MD		8 Opal		•	town, MD	21740			
	Sta		31. Date filed (Month, Day, Year) SEP 0 6	2005 32.	egistrar's Signa	ture	. 4. 1					
Re	egistr	ar i	SEPUU	LUUJ L	recon 1	U. 150	RALL					

			1 - For State WEND#1pary 09/14 Registrar VEND#100217119	/950 5 /W.W?G0	co Ce	artment of Health and rtificate of Death	Ra	2 U U J	30290
			Decedent's Name (First, Middle, Las		ALLAN	KARBELING	2. Date of Death)	3. Time of Death
	Physici /Medic		HOWARD	ALLEN	KAPBEL		Month AUGUST	Day Year 28 2005	12.19 a ^M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Location of Dear		4c. County of Dea	
			Frederick Memori	al Hospita	al	Frederick		Frederic	ck
	Funeral		5. Social Security Number 6. So	ox 7. Ag XIM 2□F	e (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min	(Month Day	Vear) C	thplace (State or Foreign ountry)
	Director		324.44.9320	61 M 20 F	51 Yrs.		Nov. 2,	1953 Chi	icago, IL
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation			10d. Inside City Limits
	Maryl	ŏ	Maryland Frederi	ck	Thurmon	nt			1 ☐ Yes 2 🗷 No
	28a	rec	10e. Street and Number	CK	Indino	10f. Zip Code	10	g. Citizen of What Co	puntry?
	3a or	Ē	521 Gateway Driv	e West		21788		U.S.A.	
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-1 show ta Marical Exa. if er r atal be neithed at	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (5	Specify Yes or No-	14. Race - Ame	
9	or ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯 I		If Yes, specify Cuban, Mexican, Puer	to Hican, etc.)	Black, Whit	
93	ours	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X No Specify:		Specify: W	nite
21215-0036	72 h 'natu	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occupation s kind of work done during most of wo	rking 1	6b. Kind of Business	/Industry
12	within ne.	mpi	Elementary/Secondary (0-12)	College (1-4or 5	5+)	DO NOT use retired)			
	lled v lygie thar t		17. Father's Name (First, Middle, Last)	2	Se	rvice Technician	mo /First Middle M	Appliance	es
and	d be f	Be	Emanuel Karbeli	nα			^{me (First, Middle, M} Brown Lee Bran	aiden Sumame)	
Ž	hould Me	²	19a. Informant's Name/Relationship (7		19h Maili	ng Address (Street and Number or R		City or Town State	Zin Codo)
Maryland	id 2 s ith an 27 is trau	1	Margery Karbelin		1				
	Hea tam	1 2	20a. Method of Disposition	g/wire	20b. Place of Dispe		Date 2	NC Marvia Oc. Location - City or	
ΩL	ages ent of nt: If i		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			matory`or other place) 8/31, emorial Gardens	/2005	Olney, Mar	vland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: If item 27 is merked other than "natural", or items 23e or 28e-f show amounts: If item 27 is merked other than "natural", or items 23e or 28e-f show any joury or other traumatic event, If a Marical Examiner and be notified at page.		21. Signature of Aneral Service Liben		2	2. Name and Address of Facility	-	-	June
ä	Depart Import any in		D-KOLKS	Home 1	OFSD 問	NES-RINALDI FÚNE 1800 New Hampshire	RAL HOME	INC. Iver Sprin	e. Mo 20904
	1 5 V		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	lication that see					Approximate
8	Physician ¹	8	Immediate Cause (Final disease or condition			AMLHYTHN			Interval Between Onset and Death
			resulting in death)	a	IN IN INC				3 MAJ 110 E
	/Medical	11	at a	Due to (or as	a consequence of):				
ř	Examiner		Sequentially list conditions		a consequence of):				
ľ	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. ————	a consequence of):				
Ž	Examiner	caminer	cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a consequence of):				
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18760,	Examiner		cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a consequence of):				
x 68760,	physician and purial-transit	edicai	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as d.	a consequence of):				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 1 - State Registrar 30291 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 30, 2005 August 7:17 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 925 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1□M 2√F New York 79 126-16-3337 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2642 Quiet Water Cove 21401 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, GiveX Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo white Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ High School Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Marco Fintz Rose Cavalier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Kellner, Son 2152 Old Dairy Farm Road, Gambrills, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State cometery crematory or other place) 09/02/05 Crownsville Veterans Cemetery 1 X Buriat 2 ☐ Cremation 3 ☐ Removal from State Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funera S Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) bediac Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 9☐Unknown Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 ☐ Yes 2 No 3 DOA 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D57028 A CHOPRA 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aueue

State Registrar

Physician

/Medical

Examiner

Director

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Certification: To

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercites trinust be notified at aging.

Physician /Medical

Examiner

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Division of Vital Records, P.O. Box 68760.

Hospital or Attending Physician:

death.

after

within 24 hours a To the Funeral D

filled in by the Director:

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year)

SEP 01

State of Maryland / Department of Health and Mental Hygien 2005 30292 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8:03 p M Kessler Stone 2005 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4565 S. Polling House Road Harwood Anne Arundel 8. Date of Birth (Month, Day, Year) 1938 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days 1 □ M 2 😡 F Hours Min. Yrs. 386-36-9726 67 Michigan Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State 7 is marked other then "natural", or items 23e or 28a-f show treumetic event, it a Modical Exscrimer mast be notified at 1 ☐ Yes 2 No Director Anne Arundel Harwood the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20776 4565 South Polling House Road USA Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White Specify: Completed by 3XXVidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Horse Trainer Equestrian and Mental Hygie Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Leah Holland (Daughter) 4565 South Polling House Rd., Harwood, MD 20776 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State o 1 ☐ Burial 2XXCremation 3 ☐ Removal from State = permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 8-25-2005 Metro Crematory Baltimore, MD 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 21. Signature of Pup ra Service Licensee <u>12 Ridgely Avenue, Annapolis, MD 21401</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Bohemuc ilans ardiomyopati /Medical Examiner Corman Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed as the burial-transit and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: for use a 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Cher (specify) P.0. the detached 9□ Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ Cerebral Vascular 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 - No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 2 this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After Division Hospital or Attanding 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 8/24/2005 MO D0041534 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kelley Willis Sullivan MD Darkway State 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 2005 30293 1 - For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Month **Physician** 2005 August 12:30 p^M Kostro Α. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Genesis Eldercare - Spa Creek Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 5, 195 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**X**□M 2□F Months Days Hours Min. Director 53 Pennsylvania 042-48-6227 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 7 is marked other then "naturel", or items 23a or 28e-f show treumatic event, the Madical Examinet must be notified at 1 ☐ Yes 2 ₩ No Director MD Anne Arundel 0denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 635 Riden Street 21113 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: if tiem 27 is marked other then "naturel", or fler eny injury or other treumetic event, the Modical Examinations. Black, White, etc. TXXYes 2 □ No 1 ☐ Never Married XXMarried Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Engineer Computers 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John B. Kostro ပ Helen Mekula 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 635 Riden Street, Odenton, MD 21113 Anne K. Kostro (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-25-2005 Metro Crematory Baltimore, MD Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Servi 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death metastatic adeno cavanoma Immediate Cause (Final Physician 3 1/2 mas disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, flary leading to in redict cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consumerous of] Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE use : 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an certificate has page 2 autopsy 2 No 1 ☐ Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 2 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Fursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After ! Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 Tyes 2 No Director: in by the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestgate Rd. Annapolis, Ma 21401 Stuaut Selouich, MO 31. Date filed (Month, Day, Year) 32. Restrar's Signature State AUG 3 1 2005 Registrar

State of Maryland / Department of Health and Mental Hygier 005 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (Figst, Middle, Last) 3. Time of Death **Physician** Or corgia 2005 023 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center

Social Security Number 6. Sex 7. Age (In yrs. last birthday) Anne Arundel Innapolis If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2√2 F 119-34-3730 64 Director 1941 New York Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2x No Director Maryland
10e. Street and Number Queen Anne's Stevensville 10f. Zip Code 10g. Citizen of What Country? 200 Terrapin Grove #304 21666 United States death Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: Completed by 3 Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "n. College (1-4or 5+) Elementary/Secondary (0-12) Customer Service retai1 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Louise Foster Julian Arthur Leve 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any injury or other traum. once. 90 Vermont Street Methuen, MA 01844 J. Oliver Kimball/ son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) Baltimore Crematory | 9-2-2005 | Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home, 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Breust Concer Priysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit requires that the death certificate be executed Cause (Lisease or injur that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physiclan/Medical d IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: Hospital or Attending : 4 hours after death. 1 Aatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a Funeral I 29a, Certifier 🗀 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 8-24-2005 D27804 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 31. Date filed (Month, Day, Year) 3 Registrar's Signature State AUG 3 1 2005 Registrar

Funeral

Director

rthen "netural", or Items 23s or 28s-f ehow the Medical Examiner must be notified at

marked other then

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permit. Pages 1 and 2:
Department of Health ar
Importent: if Item 27 is
any injury or other treu

Physician

/Medical

Examiner

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Box 68760.

Division of Vital Records, P.O.

2 should be f and Mental I

Be

Examiner

ician/Medical

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Completed

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Certification:

Medical

State

Registrar

Baltimore, Maryland 21215-0036

11. Marital Status

17. Father's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink Fosure All Copies Are Legible Ame

	Amend	item#23a,27,28a-f,perME,G847,9/17/05 TT	
	For	State of Maryland / Department of Health and Mental Hygien 2005	3029
1-	For State Registrar	Certificate of Death Reg. No.	0023

	Decedent's Name (First, Middle, Last)		2. Date of Dea Month
Physician /Medical	Benjamin Charles William Lake		SEPT.
	4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER	4b. City, Town, or Location of Death CHEVERLY	

3. Time of Death Day Year 2327 6, 2005 4c. County of Death РМ

PRINCE GEORGES Birthplace (State or Foreign Country)

Day

SEPT. 7, 2005

Year

18. Mother's Name (First, Middle, Maiden Sumame)

1 Yes

2□ No

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2 □ F Yrs 218-92-0260 41 May 23, Maryland

Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 XYes 2 No

Maryland Prince George's Cheverly Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20785 3203 Belleview Avenue U.S.A.

12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced White

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+)

Elementary/Secondary (0-12) Salesperson/Buyer Automotive

Charles Henry Lake Bernice Epperson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Bernice Lake - Mother 3203 Belleview Avenue, Cheverly, Maryland 20785

20b. Place of Disposition (Name of cametery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation | 5 □ Other (Specify) Fort Lincoln Cemetery 09/10/2005 Brentwood, Maryland

21. Signature of Puneral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Fart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Due to (or as a consequence of)

Immediate Cause (Finat disease or condition resulting in death) Cocaine Intoxication

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)

Due to (or as a consequence of)

IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify)

9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

3 Probably 4 Unknown 1 Tes 2 No

24b. Were autopsy findings available prior to completion of cause of e.th?

1X Yes 2□ No 24a. Was an autopsy performed?

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitaf: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No 2 KER/Outpatient 3□ DOA

28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending

1 ☐ Yes 2 ☑ No investigation 9/6/2005 10:50 PM 2 Accident unk Could not be determined 3 Suicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 3030 Lake Ave. 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Street

29a. Certifier (Check only one)

and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND 21201

ZAB14CLAH

31. Date filed (Month, Day, Year)

32. Registrar's Signature SEP 0 9 2005

			1 - For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of H rtificate of L	ealth and M D <i>eath</i>	lental Hygi	eng 005	30296			
	Physici /Medic		1. Decedent's Name (First, Middle, La: Nick	Lup.	is			2. Date of Death Month September	Day Yea				
	Examir		4a. Facility Name (If not institution, given Moran Manor Nur				Location of Death		4c. County of De Allega				
	Funeral Director		217-03-0200	ex 7. Age (In yrs. I M	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day, April 7	^y ear) 9. E 1912 We	Birthplace (State or Foreign Country) st Virginia			
	rland ow		Usual Residence of Decedent 10a. State 10b. County		, Town or Lo	cation				10d. Inside City Limits			
	e Man Ba-f sh	Director	MD. Allegan	y We	estern	port				X2XYes 2 □ No			
	th with th	al Dire	10e. Street and Number 240 Green St.			10f. Zip Code 215	662		g. Citizen of What United St	,			
900	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene Is markad othar than "natural", or items 23a or 28a-f show aumatic evant, the Medical Exangarat must be incifiled at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 12 2 4 es 2 □ No WW If Yes, Give Year or Dates:	2	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2% DANo	spanic Origin? (Spanic Origin? (Spanic Origin)	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi Specify: W.				
Maryland 21215-0036	filed within 72 h Hygiene. khar than "natu ant, he Medica	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) unknown	ducation de completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired rmaker	turing most of worki	ng	6b. Kind of Busines Paper Man	ufacturer			
and	id be filed wil ental Hygien kad othar th ic evant, the	To Be C	17. Father's Name (First, Middle, Last) James Lupi				18. Mother's Name						
	P = 2 =	-	19a. Informant's Name/Relationship (Steven Lupis / so		7	ng Address (Street a			City or Town, State	o, Zip Code) 21562			
Baltimore,	Pages 1 and nent of Health int: if itam 27 iry or other tr		20a. Method of Disposition **Data	Removal from State Ph	emetery, cren	sition (Name of natory or other place emetery	09/1	3/ 7	Oc. Location - City of Vesternpo:	or Town, State rt, Maryland			
Balti	permit. Page Department of Important: If any njury or once.		21. Signature of Funeral Service Licer	/ // //		!. Name and Addres	- 1	al Funer	-	nd 21562			
Í	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter I deriving a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
0	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):	- (ferre	1000		1 hour			
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ	ience of):	Artery	In seas	H		yens			
	icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequ			-						
68760	ificate be executed g physician and as the burial-transit	edical	(d									
.O. Box	death cert e attending d for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year			
rds, P	The law requires that the tee bas been signed by the base been signed by the sage 2 should be detached.	by	Part II. Other significent conditions of	ontributing to death but not resu	ilting in the ur	nderlying cause give	on in Part I.			to the cause of death? Probably 4 Sunknown			
Vital Records,		Completed			<u> </u>			24a. Was an autopsy perform	prior to				
VII a	iclan certifi rector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		. 3 DOA Othe	26. Place of Death						
on of	ding Phys h. After this funeral di	-	27. Manner of Death 1 Natural 5 Pending	(Month, Day Year)	28b. Time of Injury	28c. Injury Work	4 Grandising Hor	ne 5 ☐ Residen 28d. Describe hov	ce 6 Other (Sp v injury occurred	oecify)			
Division of	or Attan after deat Diractor: in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		me, farm, stre			28f. Location (Stre City or Town,	eet and Number or I State)	Rural Route Number,			
	a Hospital 24 hours a a Funaral letely filled	edical Co	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exam	ysician: To the best of my know niner: On the basis of examinate and manner stated.	wledge, death	occurred at the time vestigation, in my op	e, date and place, a inion, death occurre	and due to the cau ed at the time, dat	use(s) and manner are and du	as stated. ue to the cause(s)			
	To tha within 2. To tha complet	Me	29b. Signature and title of certifier			29c. License	number	290	d. Date signed (Mor	nth. Day, Year)			
)	, <i>E</i> A		· Ser	J/			244	9	9/12/2	-005			
2	+VA		30. Name and address of person who Dr.Jesus Tan,			•							
: *:	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	Socies							

			For State	State of Ma	ryland / Depa <i>Cer</i>	rtment of H		ental Hygien		30297
	Physicia	an	Registrar 1. Decedent's Name (First, Middle, Last)	Earl	Lynn	intouto or a		2. Date of Death	ay Year	3. Time of Death
	/Medic	al	Blandon 4a. Facility Name (If not institution, give s		- 7 // /	4b. City. Town, or	Location of Death	Septemb	c. County of Death	
	Examin	er		ew Drid	apt. 9	Acci	dent		Garre	1 1
	Funeral Director		5. Social Security Number 6. Sec. 175-32-4077	7. Age	(In yrs. last birthday) 65 Yrs.	Months Days	Hours Min.	B. Date of Birth (Month, Day, Yea	9. Birth Cou 940 Penn	place (State or Foreign intry) SVlvania
	ס		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	cation			7 30 F G	10d. Inside City Limits
	Maryli a-f sho	tor	MARYLAND Garret	ıt.	•	Accio	dent			1 X Yes 2 □ No
	n with the 3e or 28s	Dire	10e. Street and Number 101 Town View Drive			10f. Zip Code	21520	10g. C	itizen of What Cou USA	intry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Madical Examana must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ev Armed Forces? 1 Tyes 2 No If Yes, GiveA Year or Dates:		Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Spec n, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.
21215-0036	within 72 ho nne. than "natur is Wedical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	OO NOT use retired	turing most of working)	9 16b.	Kind of Business/l	ndustry
	buld be filed with Mental Hygiene. arked other than atic event, IIV	Be Co	12 17. Father's Name (First, Middle, Last)			Labor	18. Mother's Name (First, Middle, Maide	Labor nn Sumame)	
Maryland	should be and Mental s marked o	ToE	Theodore Lynn	- Drive	405. 44.15			Cunningha		- 0- 4-1
Mai	1 and 2 sho Health and em 27 is mo		19a. Informant's Name/Relationship (Ty Samuel Lynn, Son	pe, Print)		-	and Number or Rural Lace, #103			ρ Coσe)
ore,	Pages 1 a nent of He: int: if item iry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 F	emoval from State	20b. Place of Dispo- cemetery, cren		ı		Location - City or T	
altimore,	permit. Pag Department Important: i any injury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service License	90	Country S:		Sept 9, 20 is of Facility Newm		avidsvill 1 Homes,	
Ä	Depar Depar Impo any ir		· Ma with a	ruman	/ 17	9 Miller	St, PO Bo	x 275,Gra		, MD 21536
	Di		23a. Part1. Enter the disease, or comble shock, or hear failure. List only of Immediate Cause (Final	1 1	he death. Do not ento		g, such as cardiac or rdio Va Scu		2000	Approximate Interval Between Onset and Death
1	Physician /Medical Examiner		disease or condition resulting in death)		consequence of):	TU Cal	MIUVASCA	IVF all	Last	s years
	Examine	ē	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	ecuted and -transit	Examin	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):					
8760,	cate be executed physician and the burial-transit	dical E		d						
Box 68	leath certifical attending phy I for use as th	n/Medi	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome o		Ectopic pregnancy			23d. Date of deliv	/ery
P.O. B	that the deat ed by the attr detached for	hysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at to 9☐Unknown		Other (specify)			Month	Day Year
	w requires that the been signed by should be detacled	d by P	Part II. Other significant conditions con Diabetes Mell	tributing to death but		nderlying cause give	en in Part I.	_	use contribute to	the cause of death? bably 4 □Unknown
I Records,	The farate has	Completed by Physician/Me	Chonic obst	uctive!	pulmono	ry Dis	ease	24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
of Vital	sician certifi rector	Be	25. Was case referred to medical examiner? 1 Yes 2 No	fospital:	t 2 ER/Outpatien	t 3□ DOA Othe	26. Place of Death (ar: 4 ☐ Nursing Hom		6 DOthor (Sago	iha)
n of	ding Phys h. After this funeral di	on: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	28b. Time of	28c. Injun Work	/ at 28	Bd. Describe how inj		119)
Division	Attending r death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injur	y - At home, farm, str (Specify)		Yes 2 □No	3f. Location (Street		ral Route Number,
Ο̈́	ital or / rs after ral Dire	Certi	4 Homicide	building, etc.	(Specify)			City or Town, Sta	te)	
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edicai			f my knowledge, death examination and/or inv ed.					
	To the within To the comp	M	29b. Signature and title of certifier		AAN	29c. License	2 5 7 5 9		ate signed (Month	1,2005
	6		30. Name and address of person who co		ath (Item 23a) (Type,	Print)				1,200
	Q		Walter K Naum	onn MD	PO BOX	247.	Accident	MD 2	1520	
	Sta Regist		31. Date filed (Monts Per Year) 2	005 32. Hegistral	r's Signature	South !				

TWIN & FEDNEL LETHING LESPINASSE

		•	For Stata Ragistrar	State of Mar	yland / De <i>C</i>	partment of H ertificate of L	ealth and D <i>eath</i>	d Mental Hygi	en2 005	30298		
	Physici		Decedent's Name (First, Middle, Last Fednel Lelan		inasse			2. Date of Death Month	Day Yea	- /a /A M		
	/Medio Examir		4a Facility Name (If not institution, give	street and number)	0 1	4b. City, Town, or	Location of De		4c. County of De	ath		
	Funeral		5. Social Security Number 76. Se n/a	7	In yrs. last birthda Yrs.	Months Days	If Under 24 H Hours M	in. (Month, Day,		irthplace (State or Foreign Country)		
	Director		Usual Residence of Decedent				2 8	8/22/05	Ma	ryland		
	aryland show	_	10a. State 10b. County	1	0c. City, Town or	Location				10d. Inside City Limits		
	with the Maryland a or 28a-f show Le notified at	ecto	Maryland Worcest 10e. Street and Number	er	Ocean	City 10f. Zip Code				1 ☐ Yes 2X No		
	3a or	급	9838 Stephen Deca	tur Highwa	v.Apt.4	2184	2		g. Citizen of What (USA	Country?		
5-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Itam 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic avant, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 12 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Even Armed Forces? 1 Yes No If Yes, Give Year or Dates:		3. Was Decedent of Hi If Yes, specify Cubal	spanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - An Black, Wi	nerican Indian, nite, atc. African American		
5-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad	ication le completed)	(G:	cedent's Usual Occupa	urina most of v	vorking 16	6b. Kind of Busines	ss/Industry		
2121	12 should be filed within h and Mental Hygiene. 7 Is marked other than " traumatic avant, the Mea	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) n/a	lite	 DO NOT use retired,)		n/a			
od 2	e filed al Hygi othar vant, I	Be Co	17. Father's Name (First, Middle, Last)		n/	a	18. Mother's N	lame (First, Middle, Ma	aiden Sumame)			
ylar	ould b Ments arked	To	Fednel Lespinasse					e Rochelle				
Maryland	d 2 sh th and 7 Ism traum		19a. Informant's Name/Relationship (T)					Rural Route Number,	•	, Zip Code)		
	s 1 and f Heall fram 2 other		Fednel Lespinasse 20a. Method of Disposition		20b. Place of Dis	Box 4574, sposition (Name of prematory or other place	Salish	ury, MD 21	803 C. Location - City o	or Town, State		
E O	Page: nent o: ant: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)			ry Cremato:	1	24/05				
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 Is any injury or other tra <u>once.</u>		21 Signature of Funeral Service Licens	00		22. Name and Addres	s of Facility	ome Profes				
	707 e o		23a. Part 1. Enter the disease, or comp	ication that caused th	CFSP	501 Snow H	ill Rd.	, Salisbur	y, MD 218	Approximate		
	Dhysisian		Immediate Cause (Final	ne cause on each line.	S GOALLI DO HOLL	anter the mode of dying	, such as card	ac or respiratory arres		Interval Between Onset and Death		
	Physician /Medical		disease or condition resulting in death)	aDue to (or as a c	consequent of):							
н	Examiner		Sequentially list conditions.	b								
	pet lisit	nlne	Sequentially list conditions, if any, leading to immediate cause. Entir Underlying Cause (Disease or injury	Due to (or as a c	consequence of):							
oʻ.	execu in and ial-tra	Examiner	that initiated events resulting in death) Last	CDue to (or as a c	consequence of):							
68760,	icate be executed physician and s the burial-transit	dical		d								
	certifica oding pt use as t	w	IF FEMALE:	12a Huna automa of								
.O. Box	death e atter id for u	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 (4 ☐ Pregnant at tirn 9 ☐ Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of d Month	elivery Day Year		
Δ.	requires that the een signed by th nould be detache	by Pł	Part II. Other significant conditions co.	ntributing to death but r	not resulting in the	underlying cause give	n in Part I.	23e. Did toba	cco use contribute	to the cause of death?		
ord	w requires that been signed to should be deta							1 ☐ Yes	2 2 No 3 □ F	Probably 4 Unknown		
of Vital Records,	The la ate has page 2	Completed							prior to death?	autopsy findings available completion of cause of s 2 No		
Zi.	Physiclan: this certific ral director,	To Be	25. Was case referred to medical examiner?	lospital:	2 ER/Outpat	ient 3 DOA Cthe		eath (Check only one) Home 5 Residen	ne 6 MOther (So	ecifu)		
10		Ju: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y		of 28c. Injury		28d. Describe how		eury)		
Division	Attending r death. sctor: Alter	catle	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆 Y	es 2□No					
DİVİ	after of Dirac	Certification;	4 Homicide determined	building, etc. (- At home, farm, 'Specify)	street, factory, office		City or Town,	et and Number or F State)	Rural Route Number,		
	To the Hospital or Attans within 24 hours after deatl To tha Funaral Diractor: completely filled in by the	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exami	sician: To the best of mer: On the basis of ex and manner stated	ramination and/or	ath occurred at the time investigation, in my op	e, date and pla inion, death oc	ce, and due to the cau curred at the time, date	se(s) and manner a a and place, and du	as stated. le to the cause(s)		
	To t To tl	Σ	29b. Signature and title of certifier			29c. License	0212		. Date signed (Mor 8/31/05	ith, Day, Year)		
			30. Name and address of person who co	ompleted cause of deat	h (Item 23a) (Typ	e, Print)	c.1 00	0 21801	/			
	Sta	te	31. Date filed (Month, Day, Year) AUG 3 1	32. Registrar's	Signature	<u> </u>	9 114	2 21801	,			
	Registi	ar	HUG 9 1	LUU3 Here	a d.	Sparle						

			For State Registrar	State of M	laryland / De <i>C</i>	partment of Fertificate of	lealth and M <i>Death</i>	1ental Hy	giene 0	05	30299
	Physic		1. Decedent's Name (First, Middle	e, Last)				2. Date of De		Yeer	3. Time of Death
	Physic /Medi				pinasse			8	22	2005	1010 M
	Exami	ner	4a Facility Name (If not institution		Cala	4b. City, Town, o	r Location of Death			ity of Death	
			5. Social Security Number		ge (In yrs. last birthdi	(av) If Under 1 Year	If Under 24 Hrs.	8 Date of Bir		a Ritho	lace (State or Foreign
<i>\</i>	Funeral Director		n/a	1 % ∑M 2□F	Yrs	Months Days	Hours Min.	8. Date of Bir (Month, Da 8/22/	iÿ, Year) 05		ace (State or Foreign try) 1land
No.	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10	Od. Inside City Limits
d Fallich	death with the Maryland ma 23a or 28a-f show	ţō	Maryland Word	ester	Ocean	City					1 ☐ Yes 2 No
_ <	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Coun	try?
Elmad LESDI	23a c		9838 Stephen	Decatur High	nway #4	21842	2		USA		
137	er des Itema	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	 Was Decedent of H If Yes, specify Cuba 	fispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Ra Bt	ace - Americ lack, White,	etc.
1	rs afte	by F	1 X Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give **		1 ☐ Yes 2 💢 No	Specify:		Spec	eifv: A	frican erican
2	1215-0036 within 72 hours after then "natural", or Its Medical Emister.	ted	15. Deceder	at's Education	16a. De	cedent's Usual Occup	pation		16b. Kind of		
On	215 thin 7	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1-4or	life	ive kind of work done a. DO NOT use retired	d) most of work	ing			
3	led will her the		n/a	n/a	n	/a	40.44.4.4.4.	(F)	n/a		
lic	and The find He ed out	Be	17. Father's Name (First, Middle, Fednel Lespin	•			18. Mother's Name			,	
The state of the s	Should Me Me mark	٦ ر	19a. Informant's Name/Relations		19b. M	ailing Address (Street					Code)
3	Malth all 127 is ser trau		Fednel Lespina	sse/father		Box 4574.					
Win Act CANdice	fore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Marylar at of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Itema 23a or 28a-1 show or other traumatic event, the Medical Evaluation must be notified at		20a. Method of Disposition 1 □ Burial 2 ▼Cremation		20b. Place of Dis	sposition (Name of rematory or other place	(e)	Date	20c. Location	- City or To	wn, State
3	Page ment annt: It lury o		* 4 □ Donation 5 □ Other (S	Specify)	9	ry Cremato	0.404	/05	Salis	bury,	MD
13	Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If them 27 is marked other than any injury or other traumatic event, trauma		21 Signature of Funeral Service	Licensee		22. Name and Addre	Funeral	Home Pr	rofessio	onal A	ssociation
, -	40340		23a. Part1. Enter the disease, o	complications that cause	CFSP	501 Snow	Hill Rd.	, Salis	bury, 1	MD 218	04 Approximate
	14 TO 15		shock, or heart failure. List Immediate Cause (Final	only one cause on each	line.	ontor the mode of dyn	ig, suoir as cardiae i	or respiratory a	11031,		Interval Between Onset and Death
	Physician /Medical	П	disease or condition resulting in death)	a Due to (or a	s a conseque ce of):						
	Examiner		Constally line and like	b	1						
	D :=	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequence of):						
	D, executed an and rial-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a)	s a consequence of);						
	8760, cate be executed physician and the burial-transit			505 (5) (5) 2.	s a consequence or,						
	687 ifficate g phys	edical		0.							
	Box 68 eath certific attending p	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3 ⊟Ectopic pregnancy			23d. D	ate of deliver	ту
	O. B ne deat the att	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No			5 Other (specify)			N	Month	Day Year
	P.O. that the do	Phy	9 ☐ Unknown Part II. Other significant conditi		but not reculting in the	tradorbina opuso anu	on in Dort I	23a Did to	obacco uso co	atributa ta th	e cause of death?
	ds sign	d by	at it. Other signment conditi	one company to death	but not resulting in the	andenying cause giv	en ni Faiti.	1 🗆 1			ably 4 Unknown
	w requ	eleted						24a, Was	an 24b.	. Were auton	sv findings available
	Re(The lav te has age 2	Comple							osy rmed? 2 \square No	prior to com death? 1 \(\text{Yes} \)	sy findings available apletion of cause of
	Vital Ro	Be C	25. Was case referred to medica	1			26. Place of Death			10165	2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	of Vita Physician: rthis certific	ToE	examiner? 1 Yes 2 No	Hospital: 1 Inpat		ient 3 DOA Oth	er: 4 Nursing Ho)
	On C ding P h. After t	lon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir		ury 28b. Time ay Year) Injur	y Wor		28d. Describe h	now injury occu	rred	
	ision Attendi death. ctor: A y the fu	lcat	3 Suicide 6 Could		njury - At home, farm,		Yes 2 □ No	28f. Location (5	Street and Num	ber or Rural	Route Number,
	Div after I Direction by	Certification;	4 Homicide determ	building, e	tc. (Specify)	stroot, ractory, office		City or Tox	vn, State)		Trodio Hamber,
	Division To the Hospitel or Attending within 24 hours after death To the Funeral Director: After completely filled in by the fune	edical C	(Check only 2 Medical	ng Physician: To the bes Examiner: On the basis	of examination and/or	investigation in my or	pinion death occurr	ed at the time	date and place	nanner as sta	ated.
	thin 2, the I	Med	one) 29b. Signature and title of certifie	and manner s	tated.	29c License	e number		29d. Date sign		
	M M		> 5M	1		124	5021		8/31/		
			30. Name and address o	who co pleted cause of	death (Item 23a) (Typ	pe, Print)			0,017	2000	
			E. Percal 1	00 E. Car	1011 St.	29c. Licenson D4: D4: Salisbur	y MD	2/80/	/		
		ate	31. Date filed (Month, Day, Year, AUG 3	1 2005 32. Regist	trar's Signature	1. 4.					
	Regist	rar	nogo	The same of the sa	we st.	HOOK					

State of Maryland / Department of Health and Mental Hygiene 2005 30300 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 27, 2005 **Physician** 10:20pM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6100 West Chester Park Drive College Park, Maryland Prince Georges | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 3/29/1944 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1□ M 2√2 F Williamston, N.C 61 Director 240-68-1108 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State r than "natural", or Items 23a or 28a-f show the Modical Example roust be notified at College Park 1 Yes 2 No Prince Georges Maryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20740 6100 Westchester Park Dr. #1020 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Marned Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 反 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Private Duty Nurse 11 of Health and Mental Hygie If item 27 is marked other in other traumatic avent, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic avent page. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Louise Bowens Ernest A. Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5612 Cypress Creek #102 Hyattsville, Md. 20782 <u> Arthur B. Lee / Son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Lee Family Cemetery Sept. 3,2005 Williamston, N.C. * 4 □ Donation 5 □ Other (Specify) 21. Signatur of Funeral Service License 22 Yang and Address of Facility per Funeral Homes of P. A 5538 MariboroPike/Forestville, Md. 20747 23a. Part I. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 4 Vr S Immediate Cause (Final disease or condition resulting in death) 1etastatic Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ YPEII. 2 →No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has e 2 certificate 2 \(\text{No} \) 1 Tyes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D31001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7500 G-een way Cnt. Dr. #430 Strart T. Turkewitz MD. Green belt, on D. 20770 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Ma	ryland / De	partment of learning of learni	lealth and N Death	Mental Hygie	^{en} 2005	30301
	Physici /Medic		1. Decedent's Name (First, Middle, Las Frank M. Lease	1)				2. Date of Death Month	Day Year 26 05	3. Time of Death 3:20 #M
	Examin		4a. Facility Name (If not institution, give Sacred Hear"		tal		or Location of Death		4c. County of Deat	
	Funeral Director		217 10 0731	MM 2DE	(In yrs. last birtho	Months Days		8. Date of Birth (Month, Day,) 5-7-191 (rear) Co	hplace (State or Foreign buntry))
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	e Man le-f sh	Director	PA Somerset		Wellers	bwrg				1X Yes 2 No
	with th	Dire	10e. Street and Number 14804 Main Street	<i>+</i>		10f. Zip Code			g. Citizen of What Co	ountry?
	death ms 23	Funerai	11. Marital Status	12. Was Decedent B	ver in U.S.	15545 13. Was Decedent of I	Hispanic Origin? (Sp	ecify Yes or No-	ISA 14. Race - Ame	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23e or 28e-f show other than "natural", or Items 23e or 28e-f show event, the Medical Examinat retail be indified at	ρ	1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:	0	If Yes, specify Cub	Specify:	Rican, etc.)	Specify: Wh	e, etc. ite
15-0	"natur	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	1 (0	ecedent's Usual Occu ive kind of work done e. DO NOT use retire	during most of work	king 16	6b. Kind of Business/	Industry
212	e filed within al Hygiene other than " vent, the Mer	omp	Elementary/Secondary (0-12)	College (1-4or 5-	+)	ralman's h	•		Railroad	transport
nd	be filectal Hyg	Be	17. Father's Name (First, Middle, Last)		52.9			e (First, Middle, Ma		
Maryland	2 should be f and Mental b la marked of raumatic eve	ဥ	Ruben Buff Lease 19a. Informant's Name/Relationship (7)	ivna Printl	10h M	ailing Address (Street		Rebecca		Tim Co do l
	ロモレモ		Frank L. Lease, &						-	up code)
ore,	<u> </u>	1	20a. Method of Disposition		20b. Place of D cemetery,	804 Main S. sposition (Name of crematory or other pla	ice)			
Baltimore,	그 된 뿐 글		4 Donation 5 Other (Specify, 21. Signature of Fundal Service Licenter))	Madley	Cemetery 22. Name and Addre		-2005 B	Buffalo Mi	lls, PA
Ba	Depar Depar Impo any ir		21. Signadure of Full Hard Savice Lice				•	Functal H	lome, Hyndi	main DA
V.	Pnysician /Medical		23a Part 1. Enter the disease or conc shock, or heart failure List only of Immediate Cause (Final disease or condition resulting in death)	a.	9.	enter the mode of dyi	ng, such as cardiac	or respiratory arres	t, ingrici	Approximate Interval Between Onset and Death
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	ned Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underving Cause (Disease or injury	Due to (or as a	consequence of):					
o,	icate be executed physician and s the burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
38760,	cate b physic the bu	edical		d.						v-
O. Box	death certif e attending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 24 □ Pregnant at 19 □ Unknown	Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of deli Month	ivery Day Year
<u>α</u>	law requires that the de as been signed by the a 2 should be detached f	by Pr	Part II. Other significant conditions co	ntributing to death bu	t not resulting in th	e underlying cause gr	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ord	w require been sign should b		Dehydralion	ι					2 X No 3 □ Pro	obably 4 Unknown
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/ital	Physician: Th this certificate ral director, pag	BeC	25. Was case referred to medical examiner?	U				h (Check only one)	110 12:00	2,3110
of	this al di	1: 70	1 ☐ Yes 2 🔀 No 27. Manner of Death	Hospital: 1 Minpatier 28a. Date of Injur	-	tient 3L DOA		ome 5 Residence	ce 6 ☐Other (Speciniury occurred	city)
ion	r Attending Fier death. Frector: After by the funera	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day		ry Wo	rk? Yes 2 □No		.,.,	
Division	or Atte after de Directo in by th	ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc.	ry - At home, farm (Specify)	street, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
_	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	ledical C	29a. Certifier (Check only one)	rsician: To the best of iner: On the basis of and manner state	examination and/o	eath occurred at the ti r investigation, in my o	me, date and place, opinion, death occur	and due to the cause	se(s) and manner as and place, and due	stated. to the cause(s)
)	To the I	M	29b. Signature and title of certifier	Chotani		29c. Licens	5 8 8 5 3	29d	Date signed (Month)	
	(3		30. Name and address of person who co		ath (Item 23a) (Ty	Pe, Print)	IA AVE,	CUMBE	RLAND,	MD21502
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 9 2	32. Resistra	r's Signature	Sparte				

State of Maryland / Department of Health and Mental Hygien 2005 30302 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 45 A.M. Nancy Elizabeth Layton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NEART HILL GAN officied **Funeral** 5. Social Security Number Age (In yrs. last birthday) Birthplace State or Foreign Country) 1 □ M 2 X F Yrs. Director 65 215-36-9178 06-Mar-1940 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Modical Execution in structure. Director 1 1 Yes 2 No Grantsville Maryland Garrett 10e. Street and Number 27 Pullin Hollow Road 10f. Zip Code 10g. Citizen of What Country? 21536-U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 M Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: if item 27 is marked other than "r any niury or other traumatic event, it a Madonce. Elementary/Secondary (0-12) College (1-4or 5+) State University housekeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Lawrence L. Layton Clara McKenzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1154 Finzel Road Lawrence Layton Frostburg 21532 Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ★ Burial 2 □ Cremation 3 □ Removal from State 30-Aug-2005 Finzel Layton/Arnold Cemetery Maryland 21. Signature of Funeral Service Li 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 ohn 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician byas disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 0160100 Sequentially list conditions, Examiner frank leading to inmedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-transit The law requires that the death certificate be executed Carobio and to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? twis selevosi 1 ☐ Yes 2 ☐ No 2 No Division of Vital 1 ☐ Yes Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 1 ☐ Yes 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hours after within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 13233 3 cause of death (Item 23a) (Type, Print) 30. Name and address of person Cumberlanc 91 OR. ARMUAHAN DRIVE 31. Date filed (Month, Day, Year) 32. Registar's Signature State AUG 3 0 2005 Registrar

			1- State of Maryland / Department / Department / Department / Department / Department / Departme	artment of Health and M rtificate of Death	lental Hygi	iene g. N2 0 0 5	30303
	D		Decedent's Name (First, Middle, Last)		2. Date of Death	h	3. Time of Death
	Physici /Media		Hilda Mae Marvel		August	31, 2005	20:42 PM
	Examir	ier	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	h
			Peninsula Regional Medical Center	Salisbury		Wicomic	
п	Funeral Director		5. Social Security Number 6. Sex 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birtl	hplace (State or Foreign untry)
			222-09-1256 S8 Yrs. Usual Residence of Decedent		4-1-1917	/ De	laware
	yland		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	e Ma	cto	Delaware Sussex Ocean Vie	2W			1√2 Yes 2 □ No
	or 20	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?
	s 23s	-E	13 Daisey Avenue	19970		United Sta	
	Item	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
39	urs af	by F	1 ☐ Never Married 21区 Married 1 ☐ Yes 2 図 No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: W	hite
9	be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural" or Items 23e or 28e-1 show odner, the Medical Ever's at mast be redified at	Completed by	15. Decedent's Education 16a. Decedent	dent's Usual Occupation	1	6b. Kind of Business/I	Industry
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2	e filed within al Hygiene. I other than vant, the Me	Con	c 7 School	1 Bus Driver		Transporta	
and		Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, M.	laiden Sumame)	
<u>=</u>	d 2 should be th and Menta ?7 Is marked traumatic ev	은	Archie Frank Savage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailir		n Wainw		
Maryland 21215-0036	d 2 s h ar 7 ls trau	1	man a man a man a man a man a man a man a man a man a man a man a man a man a man a man a man a man a man a man	ng Address (Street and Number or Rura			îp Code)
Baltimore,	s 1 and 2 if Health item 27 l	1		isey Avenue, Ocean		DE . 199/0 0c. Location - City or 1	Town, State
E O	Page: ent o nt: If I		1 Buria 2 Cremation 3 Removal from State Dagsboro Memoria 1	sition (Name of natory or other place) Redmens	_		
alti	mit, partm porta y inju		Tellorial	Cemetery 9-4-0 Name and Address of Facility Son Funeral Servi	<u>טע</u> כע	agsboro, De	elaware
B	permit, Pages 1 a Department of He Important: If Item any injury or oths	N d	The The The	atcher St, Frankfo	ices, Lto ord. Dela	d. aware. 199 <i>a</i>	45
			23a. Part T. Enter the disease, or complications that caused the death. Do not ent shock, or heart failute. List only one cause on each line.	er the mode of dying, such as cardiac o	r respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Subdural Len	raton A			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				
		-	Sequentially list conditions, if any, leading to immediate b. Subarachord. Due to (or as a consequence of):	Hemorrhage			48
	uted I Insit	m L	cause. Enter Underlying Cause (Disease or injury	Eall			
Ć,	exection and and rial-tra	Examiner	resulting in death) Last c. Due to (or as a consequence of):	-(11			
8760,	cate be executed physician and the burial-transit	dical	d				
9	ng ph	Med	IF FEMALE:				
Вох	death certific e attending pl id for use as t	an/l	23b Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of deliv	•
0.	the a	Physician/Me	1 ☐ Yes 2 2 No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Month	Day Year
<u>α</u>	that the d		Part II. Other significant conditions contributing to death but not resulting in the ur	aderiving cause given in Part I	23a Did toba	icco use contribute to	the source of death?
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ita		0	25. Was case referred to medical	26. Place of Death	(Check only one)		2 □ No
of V	d S	To B	examiner? 1 Pes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	04		ce 6 ☐Other (Specia	fv)
0	ding PI I. After th		27. Manner of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of Injury 28b. Time of Injury		8d. Describe how		
<u>s</u>	Attanding ir death. ector; After by the fune	cati	2 Accident investigation 8 2 9 05	M 1 □ Yes 2 1 No	Fround	Lovel Fe	113
Division	I or Attanc after death Director; I in by the	Certification:	4 Homicide 28e. ace of Injury - At home, farm, streen building, etc. (Specify)		City or Town, a	et and Number or Rura State)	
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	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or inv	estigation, in my opinion, death occurre	d at the time, date	se(s) and manner as s e and place, and due to	o the cause(s)
	To th withir To th comp	M	29b. Signature and title of certifier	29c. License number	29d	I. Date signed (Month,	Day, Year)
)			· (hu)	45 0497		8/31/0	_
_	- F	1	30. Name and address of person who completed cause of death (Item 23a) (Type, I	Print)	,	1-0	
ک) (0		Chris Snyder 100 2. CAMOIL	St. Salesbuy	mo 2	1081	
1	Sta Registra		31. Date filed (Month, Day, Year) SEP 0 6 2005 SEP 0 6 2005	artie			
		. 4	OLI OU COOL MANAGEMENT OF JOS				

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State Registrar Paola

31. Date filed (Month, Day,

Unwerstyo

32. Registrar's Signature

Manufand Moderal Center pager 4103892227

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar	ite of Mary	nand / De <i>C</i>	partment of F ertificate of	leaith and iv Death	rentai myg	Reg. No.	005	30305		
ı	Physicia	an	1. Decedent's Name (First, Middle, Last)	T.T.				2. Date of Dea Month	Day		3. Time of Death		
	/Medic	al	David Williar MARSHA 4a. Facility Name (If not institution, give street			4b. City, Town, o	r Location of Death	Sept. 2		County of Deat	4:20 a. M		
	Examin	er	459 Pangborn Bouleva			Hager	stown		1	Washing	ton		
	Funeral Director		5. Social Security Number 6. Sex 1数 M 2	7. Age (II	n yrs. last birthd 7 Yrs	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da Aug. 18			hplace (State or Foreign suntry) 'yland		
	and w		Usual Residence of Decedent 10a. State 10b. County	10	Dc. City, Town or	Location					10d. Inside City Limits		
	Maryli f sho	Maryland Washington Hagerstown									1⊠Yes 2 No		
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What Co	ountry?		
	ath wi	rai	459 Pangborn Bouleva				21742	N		SA			
036	2 should ba filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28e-f show aumatic event, Ir a Madreal Experience, and be neitlised at	by Funerai	1 № Never Married 2 Married 1	as Decedent Eve med Forces? □Yes 2₺ No Yes, Give ear or Dates:	erin U.S.	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔯 No		ecry Yes or No- Rican, etc.)	-	14. Race - Ame Black, White Specify: Wh	ncan Indian, e, etc. nite		
S C	72 ho	eted	15. Decedent's Education (Specify only highest grade com	pleted)	16a. De	cedent's Usual Occup ive kind of work done b. DO NOT use retired	ation during most of work	ring	16b. K	ind of Business/	Industry		
Maryland 21215-0036	within ene. than than	Completed	Elementary/Secondary (0-12) C 12	Ollege (1-4or 5+)	1	inter	a)			planing	g mill		
2	ba filed tal Hygi d other event, I	Be Co	17. Father's Name (First, Middle, Last)	0	1 -		18. Mother's Name	e (First, Middle,	Maiden	<u> </u>			
<u>Ja</u>	should ba	To B	John Henry Marshall				Ha1s	sie Leon	a R	ife			
Jan J	l 2 sho		19a. Informant's Name/Relationship (<i>Type</i> , <i>P</i> Sharon Dattilio — fr			ailing Address (Street Pangborn							
e,	1 and Health Iem 27		20a. Method of Disposition			sposition (Name of crematory or other place		Date		cation - City or			
Baltimore,	permit. Pages 1 and 2 should bi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic et 900.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	al from State		ill Cemete	ry 9/6/				, Maryland		
Ba	permi Depa Impo any le		21. Signature of Funeral Service Licensee	news	Le.	22. Name and Addre							
ł	- 1		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call	s that caused the							Approximate Interval Between		
air.	Physician		Immediate Cause (Final disease or condition CARDIOPULMONART ARREST										
	/Medical Examiner		resulting in death)	Due to (or as a consequence of): ATHEROSCIEROTIC HEART DISEASE b. ATHEROSCIEROTIC HEART DISEASE									
		er	Sequentially list conditions, in any, leading to immediate	Due to (or as a c	unsequence of).	OTIC IT	EARI	0(30)					
	cutad nd ransit	Examiner	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							E			
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P.O. Box	The law requires that the death certificate be exacuted ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/M	in the past 12 months?	yes, outcome of p □Live birth 2 [□Pregnant at tim □Unknown	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	<u>′</u>			23d. Date of del Month	ivery Day Year		
ري ص	res that signed by be deta	y Pr	Part II. Other significant conditions contribu	ing to death but r	not resulting in th	e underlying cause giv	en in Part I.	23e. Did to	obacco u	use contribute to	the cause of death?		
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o	Attending Physician: or death. ector: After this certifici by the funeral director,	n: To		a. Date of Injury (Month, Day Y	28b. Tim	e of 28c. Injur	y at	28d. Des ribe l		occurred ∫	city)		
ion	anding ath. or: Afte	atio	1 Natural 5 Pending investigation	(World, Day 1	ea <i>r)</i> Inju	,	Yes 2 □ No						
Division of	ial or Attending s after death. al Director: After ed in by the fune.	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28	e. Place of Injury building, etc. (- At home, farm Specify)	street, factory, office		28f. Location (S City or Tox	Street an vn, State	d Number or Ru)	ıral Route Number,		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai (29a. Certifier 1 Certifying Physicial (Check only one) 1 Medical Examiner:		amination and/o								
ı	To the I within 2 To the Complet	ž	29b. Signature and title of certifier	M.	1) .	29c. Licens				te signed (Monti			
,				/ '	- Man - 22 : =	200	061411		00	102/2			
5h	1-3		30. Name and address of person who comple MAHESH KR IS	itNAM C	ORTH	>, 1(110 (MEDICAL	L CAMI	945	RA. H	MD 21740		
	Sta Regist	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHESH KRISHNAMOORTHY, 1110 MEDICAL CAMPUS PD. HAGERSTOCON State SEP 0 6 2005 32. Registrar's Signature SEP 0 6 2005											

DHMH 17 Rev 1/2001

AEM # 05-06185 amend 9 per Fullase 8% pe or Print the BIER Indelible Ink. Ensure All Copies Are Legible. Makayla Montielor Amend Item 4c&Unpend Item 23a&27 rper are 0684211-10-05 tasked No. 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 9, 2005 **Physician** Makayla I. Montiel 4:19 Pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, May 31, 9. Birthplace (State or Foreig Country) **Wash** Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 200 F 0 Director 214-73-7443 Yrs Usual Residence of Decedent Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits il Hygiene. I other then "naturel", or iteme 23a or 28a-1 enov ivent, ite Mudical Examiner must be notified at Maryland Prince George's Lanham 1 1 Yes 2 □ No Directo the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9202 McHenry Lane 20706 USA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or item eny injury or other treumetic event, the Medical Experiment DDRs. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 StYes 2 □ No Specify. Specify: Hispanic 3 ☐ Widowed 4 ☐ Divorced El Salvadorian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Angel Tomas Garcia Karen Montiel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9202 McHenry Lane, Lanham MD 20706 Angel Garcia (Father) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National 9/14/2005 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature J Fineral Service Licensee 22. Name and Address of FacilitRendon/Hale Funeral Home 9013 Annapolis Road, Lanham MD 20706 23a. Part. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List goty one cause on each line. Approximate Interval Between Onset and Death lamediate Cause (Final disease or condition resulting in death) **Physician** Sudden Infant Death Syndrome(SIDS) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed physicien and sthe burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 1 ☐ Yes 2 XNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records. been signe should be o 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Kinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an death? 1∕S Yes 2 □ No certificate 1 XYes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐XYes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 □ DOA After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred A safter dea. 5 Pending investigation 1 Tes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours all To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME September 11, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kus oli Penn Street Baltimore, Maryland 21201 ANA 31. Date filed (Month, Day, Year) Registrar's Signature State SEP 1 3 2005 Registrar

DHMH 17 Rev 1/2001

		1- State of Maryland / De State of Maryland / De 29d per dr., G849	partment of Health and Mo 11,79,05dhb enfincate of Death	ental Hygien Reg. N	2005 30307
Physic /Med		1. Decedent's Name (First, Middle, Last) Michael J. Marshall		2. Date of Death August 2	3. Time of Death 11:45A M
Exami		4a. Facility Name (If not institution, give street and number) 1321 Hallock Drive	4b. City, Town, or Location of Death Odenton	4	c. County of Death Anne Arundel
Funeral Director	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 95 Yrs	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Aug 27 1	9 Rirthplace (State or Foreign
Maryland -1 show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arundel Odento			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
with the e or 28a be notii	Director	10e. Street and Number 1321 Hallock Drive	10f. Zip Code	10g. C	Citizen of What Country?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or Items 23e or 28a-1 show any njury or other traumetic event. The Mutical Examinat must be notified at any once.	by Funeral		21113 3. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto F 1□ Yes 2X No Specify:	cify Yes or No- lican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: Black
Maryland 21215-0036 d 2 should be filed within 72 hours at the and Mental Hygiene. 27 Is marked other than "netural", or traumetic event, the Wurltcal Exem	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of workin DO NOT use retired) rmer	g	Kind of Business/Industry
rland Z uid be filed Aental Hygi rkad other tic event, I	To Be Co	17. Father's Name (First, Middle, Last) James Marshall		(First, Middle, Maide	
Mary nd 2 shot alth and N 27 ta mai		19a. Informant's Name/Relationship (Type, Print) Gladys Johnson(Daughter) 132	iling Address (Street and Number or Rural 1 Hallock Dr. Od	Route Number, City enton, M	or Town, State, Zip Code) Id. 21113
Baltimore, perrit. Pages 1 ar Department of Hea mportent: If item any njury or other page.		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 1 Memoria	rematory or other place) +		Location - City or Town, State
Balt permit Departr Importe any nji		21. Signature of Funeral Service Licensee Larry B. Reese MO0483	22 Name and Address of Eacility Ons Wm. Reese & Sons 821 West St. Ann	apolis,	y, P.A. Md. 21401
Cate be executed Cate be executed Cate be executed Cate by Sician and Cate by Prize Ca	dicai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	inter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
BOX 6 death certifi e attending	Physician/Med		B □Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
O 8 P 9	b	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death?
The ate h	e Completed	25 Wee see a found to a stirry		24a. Was an autopsy performed? 1 Yes 2 N	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No
Phys r this	To B	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat 27. Manner of Death 1 Natural 5 Pending (Month, Day Year)	of 28c. Injury at 28		6 □Other (Specify) ury occurred
DIVISION (Nor Attending I after death. Director: After d in by the funer	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No street, factory, office 28	Bf. Location (Street a City or Town, Sta	ind Number or Rural Route Number, te)
Hospita 4 hours Funaral ely fillec	edical Ce	29a. Certifier (Chack only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, ar investigation, in my opinion, death occurred	nd due to the cause(d at the time, date ar	s) and manner as stated. In place, and due to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	D2G44	1 A A	ate signed (Month, Day, Year)
	1 2	30. Name and address of person who completed cause of death (Item 23a) (Typ ANDREW DOBIN 4175 NORTH	Hanson Ct. Be	2.203A SW/E.M	d 107/6
St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 3-1 2005 32. Registrar's Signature	South)		

State of Maryland / Department of Health and Mental Hygien 2005 For State Registra 30308 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 2005 August 27, 1:41Thomas Wilbur Marceron /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda If Under 24 Hrs. If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Nov. 3, 1914 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min Months Hours 157M 2□ F Yrs. 90 Washington, DC Director 213-44-6471 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo 01ney Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20832 USA 18200 Bluebell Lane within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specity: Specify ð 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Systems Analyst 12 Supervisor permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies important: if item 27 is marked other than any injury or other traumatic event, in once. Federal Government filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ Effie Tydings John Albert Marceron 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18200 Bluebell Lane Olney, Maryland 20832 Ann M. Rivkin Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Colesville Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Sep. 5, 2005 Colesville, Maryland Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of) Examiner Gastrointestinal Bleed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Dualty (or as a surresquarise of) use as the burial-transit death certificate be executed that initiated events resulting in death) Last been signed by the attending physicien and should be detached for use as the burial-trai Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic prøgnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) 9□ Unknown The law requires that the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 1 ☐ Yes 2€ No _ 2 😡 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 XNatural death. 1 Yes 2 No filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building. etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö within 24 hours a the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 27660 August 29, 2005 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 Alpana Goswami M.D. 1119 Rockville Pike Rockville, Maryland 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 01 2005 SEP Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 15 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yeer Physician Month 2005 28 11:08 A <u>Ana Beatris Montepeque</u> August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10513 Tenbrook Drive Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🔀 F Director 212-68-0676 59 Nov. 26. 1945 El Salvador Usual Residence of Decedent the Maryland 10a. State 10c, City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Medical Examiner must be notified at 1 Yes 21 No Director Silver Spring Maryland | Montgomery 10e. Street and Number 10g. Citizen of What Country? 72 hours after death with 10513 Tenbrook Drive 20901 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ¥ Yes 2 □ No Specify: White \$ 3 ☐ Widowed 4 X Divorced Salvadoran Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages t and 2 should be tiled within nent of Health and Mental Hygiene. ont: if item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Babysitter Child_Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Salvador Montepeque Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10513 Tenbrook Drive Delmy R. Segovia Daughter Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven 20a. Method of Disposition 20c. Location - City or Town, State o b permit. Pages Department of I 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State injury o * 4 ☐ Donation 5 ☐ Other (Specify) Sep.1,2005 Silver Spring, Maryland Cemetery 21. Signature Furjeral Service Licensee 22. Name and Address of Facility any in Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications this caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Arteriosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): the attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 **2**Yes 2 □ No Medical Certification: To After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 XNatural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funeral Director: 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 29a. Certifier 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check of one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifier

5

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State 31. Date filed (Month, Day, Year)
Registrar SFP 01

I. Margolis, M.D. 11125 Rock (Month, Day, Year) 32 Registrar's Signature SEP 01 2005

(CIME)

MG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11125 Rockville Pike Rockville, Maryland 20852

D

15236

August 29, 2005

30310 State of Maryland / Department of Health and Mental Hygien () [] 5 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yeer **Physician** 05 enned rene /Medical 4c. County of Deeth acility Name (If not institution, give street and number) City, Town, or Location of Death Examiner Anne Anunde Medical Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, 7. Age (In yrs. last birthday) acurity Number 6. Sex 1 M 20 F Year) **Funeral** Days Min. A Hours Months Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director 5 COPPE ACP 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe or Itema 23a or 20 1 ted (Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: 11 Marital Status within 72 hours after ↑ Never Married 2 Married 1 Yes 2 Maryland 21215-0036 Specify Specify: Black þ 3 Widowed 4 Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Dionne Keainald 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Info. ant's Name/Relationship (Type, Prin linton Md lionne Knight if Health a Hed an 000 Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) intment of l 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ö 9-2-2005 Department Important: fi any injury o MD etro 21. Signature of Funeral Secret Licensee 22. Name and Address of Facility
Hardesty Funeral Home, P.A permit. 70 12 Ridgely Avenue, Annapolis, MD 21401 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, of complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) mi **Physician** /Medical Due to (or as a consequence of): Examiner laterna Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months?
1 Yes 2 PNo 5 Other (specify) 4☐Pregnant at time of death by the a 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 76 3 Probably 4 Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performed? page 2 No 2 X No 1 Yes certificate or Attending Physician: ector. 25. Was case referred to medical 26. Place of Death Check only one Be examiner' Hospital: 1 Shortient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA Medical Certification: To 2 ER/Outpatient ij this 28a. Dale of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 27. Manner of Death . After Injury Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. in by the within 24 hours after deat To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) To the I 29d. Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certifier D39703 cause of death Mem 23a) (Type, Print) 001 Medical 31. Date filed (Month, Day, Year) 32. Rigistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

AUG 3 1

ORIGINAL

Please Type or Print in Black					
State of Maryland / D	epartment of Health and Certificate of Death		e2e()	05	30311
Decedent's Name (First, Middle, Last)		2. Date of Death		Van	3. Time of Death
GRACE LUCILLE MORTON		AUGUST	31	2005	11:00 A ^M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De	eath	4c. Co	ounty of Death	

Physician /Medical Examiner

4a. Facility Name (If not institution, give street and number)

Funeral Director

in then "natural", or iteme 23a or 28a-f show the Modical Examiner must be notified at death hours after filed within 72 I al Hygiene. other traumatic svent, 90 t of Health and Mental If Itsm 27 is marked o Pages permit. Pages Department of Important: If It sny injury or c

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans attending use jo the detached ģ signed t page 2 s certificate this funeral After death. within 24 hours after deal To the Funeral Director:

901 BARNETT LANE APT 308 ABERDEEN HARFORD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6 SAY 5. Social Security Number Months Davs Hours Min. 1 □ M 2 🗓 F 85 March 19, 1920 Maryland 217-16-8582 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 17 Yes 2 □ No Maryland Harford Aberdeen Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 901 Barnett Lane, Apt 308 21001 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: Black ð 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) University Housekeeping 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Carroll Lee Susie Cole 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gloria M. Smith / sister 516 Revolution Street, Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State St. James United Cem. 9/7/05 Havre de Grace, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lisa Scott Funeral Home, P.A.
552 Lewis Street, Havre de Grace, MD 21078 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 50 Due to (or as a consequence of) s a consequent of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner 21 to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 2 No 4 \(\sum \text{Unknown}\) 1 ☐ Yes Completed 24a. Was an autopsy performed? / 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Schesidence 6 Other (Specify) 2 1 ☐ Yes 💘 ☐ No 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Mannef of Death Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No M 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address if person who completed cause of death te 3ay ype, Print 32. Registrar's Signature State 2

Registrar

2005

State of Maryland / Department of Health and Mental Hygiene [] [] 5

30312 1 - For State Registrar Certificate of Death Req. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) AUGUST 29, 2005 **Physician** 6:15P M BERNICE ANN MASTERSON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel 2614 Compass Dr. Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea 4-26-1920 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Yrs. Pennsylvania 85 Director 166-14-1012 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Annapolis Anne Arundel Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 21401 USA or Items 23a 2614 Compass Dr. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White nature!' 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Home 12 should be filed w h and Mental Hygier 7 is marked other tl 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elizabeth Redding John McClimate 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ent: If item 27 is Robert C. Masterson/ Husband 2614 Compass Dr., Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. injury or 9-2-05 MD Veterans Cemetery Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 21. Signature of Funeral Service Livensee Mull MD, 21037 2973 SOLOMONS ISLAND ROAD, EDGEWATER 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 3 days Physician Myocardia resulting in death) /Medical Due to (Ir as a consequence of) **Examiner** Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Live birth Month Day for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ should be 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 1 ☐ Yes 2 ☐ No 1□ Yes 2 7 No this certificate or Attending Physicien: funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA Certification: To 28a. Date of Injury (Month, Day 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide n 24 hours af se Funeral D stetety filled in 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 To the To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Chata 04529 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31 Robinson Rd., Severna Park, MD 21146 Elaine M. Arata, M.D. 32. Restrar's Signature 31. Date filed (Month, Day, Year) State AUG 3 1 2005 Registra

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Exami	ner	4a. Facility Name (If not institution, give stre 1416 Mason Street	et and number)			or Location of Deat	h	4c. County of D	eath			
Funeral Director		5. Social Security Number 6. Sex	2□ F 7. Age (In yrs. 35	/ast birthday) Yrs.	Baltimo If Under 1 Year Months Days	r If Under 24 Hrs	(Month, D	ay, Year)	Birthplace (State or Forei Country) ASHINGTON D			
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death v		1416 MASON STREET 11. Marital Status 12.	Was Decedent Ever in U	I.S. 13. V		1217 Hispanic Origin? (S	pecify Yes or N	U.S.A.	merican Indian.			
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or itema 23a or 28a-f show event, ite Madical Examitar must be rigitified at	d by Funeral		Armed Forces? 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		f Yes, specify Cull	Hispanic Origin? (S ban, Mexican, Puerl o Specify:	o Rican, etc.)	Black, W	hite, etc.			
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and leelth im 27 her tr		19a. Informant's Name/Relationship (Type, ROBERT MICHAEL MORR	ISON/FATHER	12803	KEMPER	LANE, BOY	WIE, MAR		15			
Pages 1 ar nent of Hee int: If item; iry or other		20a. Method of Disposition 1 ☐ Burial 2 🕅 Cremation 3 ☐ Rem	oval from State	cemetery, cren	sition (Name of natory or other pla	1	Date	20c. Location - City	or Town, State			
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Physician /Medical Examiner		shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, b.	ause on each line. Stranculation Due to (or as a conseq		<u></u>				Interval Between Onset and Death			
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	0		30. Name and address of person who	completed cause	of death (Item 23a) (Type		00							
	10				MEDICAL CNT		OFFICE	ROAD WA	LDORF MD 20	602				
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State of Maryland / Department of Health and Mental Hygien 2005 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician VIOLET E. MADSEN 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Micomico Medical CENTE SAL136UN HENINSUM REGIONA If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year)
1/22/1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 ☐ F 79 NY. 078-20-1665 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at WICOMICO 1 Yes 2 No Director TYASKIN 10e, Street and Number 10f. Zin Code 10g. Citizen of What Country? 21633 WETIPQUIN RD. 21865 23a USA Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: Specify: WHITE Widowed 4 ☐ Divorced "natural". 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) RETAIL PETS is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 8 CAT BREEDER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be find Mental I GEORGE WILLIAM McBRIDE CATARINA STAKOVA ျှ and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 95 LINCOLN AVE. ALBANY.NY. LINDA GIORDANO DAUGHTER 12206 Health Item 27 i Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages 1
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important: if Itel
any injury or ott LAUREL GROVE CEM. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/3/2005 OTOTAWA, NJ. `4 □Donation 5 □ Other (Specify) 21, Signature of Funeral Service Licensee 22. Name and Address of Eacility RAL HOME PO BOX 61 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myo coandinal /Medical Due to (or as a consequence of): Examiner 65:11 Atom Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Due to (or as a consequence of): 68760. ed by the attending physicien detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Donknown r this certificate has been si ral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform Vital 1 ☐ Yes 2 10 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, examinar? Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 ENatural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Implication of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier HODIS697 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Newton ST Salisby MD 2180) 218 32. Rastrar's Signature 31. Date filed (Month, Day, Year) State AUG Ó 1 2005 Registrar

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11016

CTAmend/Unpend 1 ten#1,23a,27,28a-f, perME, G849,11-15-05, 171
State of Maryland / Department of Health and Mental Hygiene Corp. 05-06022 Norman, Dwayne 1 - For State Registrar 30316 Amend item1, perME, G869, 114-223-05 Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dewayne Norman Day Dwayne Norman Month **Physician** 3:57 PM^M DeWayne September 3, 2005 Norman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1√2 M 2□F Months Hours 31 578-88-5643 1974 Washington, Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County il Hygiene. Johner then "natural", or iteme 23a or 28a-f ehov vent, the Madical Examinar must be notified at 1X Yes 2 □ No Temple Hills Director Maryland Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 2317 Jameson Street United States Completed by Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unemployed 12 i. Pages 1 and 2 should be filed vitnent of Heelth and Mentel Hygie trant: if Item 27 is marked other flury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Juachita Norman 2 Billy Jackson, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juachita Jackson / Mother 2317 Jameson Street Temple Hills, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: if eny injury or appear. Sept.10,2005 Landover, Md. Harmony Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat re f Funeral Service Gensee 22 Name and Address of Facil Alexander S. P 5538 Mariboro Pöpe Funeral Homes. P:A Pike/Forestville, Md: 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Blunt force head injury with complications /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to animodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the ettending physicien and hed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 cete hes been sig , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 \sum No 24a. Was an autopsy 1X Yes 2 ☐ No Division of Vital After this certification funeral director, or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 2 1 X Yes 2 □ No 2 XER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of InjuryUnk 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending death. investigation 2 Accident 6/12/05 efter death Director: subject assaulted Location (Street and Number or Rural Route Number, City or Town, State) 13400 Dile Drive 6 Could not be determined Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Prince George's 4 Homicide Largo, Maryland 24 hours e Funerai [County Jail Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) OCME September 4, o completed cause of death (Item 23a) (Type, Print) 30. Name and address of person JAKK M. TIMI M.D 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) . Registrar's Signature State SEP 1 3 2005 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 30317 1 - For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month James /Medical 1:40 P 08 28 054a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Adventist HOspital Takoma Park
If Under 1 Year If Under 24 Hrs. Montgomery **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1**□**M 2□ F Hours Yrs Director 259-28-8468 10 10 15 89 Georgia Usual Residence of Decedent with the Marylend 10a State 10b. County 10c. City, Town or Location or than "natural, or Itams 23a or 28e-f show the Medical Examinar must be notified at 10d. Inside City Limits Director 1 ☑ Yes 2 ☐ No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? daath 8505 Springville Road by Funera 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours efter 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7/ ih and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) 7th. Mechanical Engineer Research Analyst Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ed Nix Ida Jordan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ges 1 end 2 s nt of Health an : If itsm 27 Is Bonnie Roundtree/Daughter 6918 New Hampshire Ave. Takoma Park, MD. 20912 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Peges 1
Department of H
Importent: If Ital
any injury or ott 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 09-02-05 MAryland National Laurel, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall's Funeral Home Marshal 4217 9th. St. N.W. Washington, D.C. 20011 23a. Parti Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificete be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No jo 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.0. the detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificete 1 🗌 Yes 25 No the Hospitel or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 25 No 2 ER/Outpatient 3 DOA Inpatient this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending aftar daath. 1 ☐ Yes 2 ☐ No investigation M 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. vithin 2 29b. Signature and title/o 29c. License number 29d. Date signed (Month, Day (Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Yeheyis/Negussie, M.D. 7600 Carroll Avenue, Takoma Park, MD. 20912 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar SEP 0 2 2005

			for State Registrar	State of Ma	ryland / Depa	artment of He	ealth and Me Death		2005	30318			
			1. Decedent's Name (First, Middle	ə, Last)				2. Date of Death Month	Day Year	3. Time of Death			
	Physicia /Medic		Lily	Margaret	Neill		\$	eptember		5:15 a	И		
	Examin		4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, or L	ocation of Death		4c. County of Dear	_			
			St. Mary's Nur			Leonardto			St. Mary				
	Funeral Director		5. Social Security Number 214-72-4843	6. Sex 7. Age	90 (In yrs. last birthday)	If Under 1 Year Months Days	Hours Min	B. Date of Birth (Month, Day, Y June 7,	'ear) Co	hplace (State or Foreig ountry) yland	חן		
	pug w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limit	s		
	Aaryli f sho	5		Mary's	Hollyw	rood				1 ☐ Yes 2X N	0		
	28a-1	Director	10e. Street and Number	Haly 5	HOLLYW	10f. Zip Code		100	. Citizen of What Co	ountry?			
	with Mary		45210 Nats Cre	ek Road		20636			USA				
	ns 2%	era	11. Marital Status	12. Was Decedent E	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cuban,	panic Origin? (Spec		14. Race - Ame				
36	permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exactilise it set to notified a once.	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give	lo		, Mexican, Puerto R Specify:	ican, etc.)	Specify:	e, etc. Thite			
21215-0036	2 hou	ted		nt's Education	16a. Dece	dent's Usual Occupat	ion	16	b. Kind of Business	/Industry			
215	hin 7. In "n Medi	Completed	(Specify only higher Elementary/Secondary (0-12)	completed) College (1-4or 5	life.	kind of work done du DO NOT use retired)	iring most of working	9					
217	d with giene ar tha	mo;	6			e Maker		O	wn Home				
ק	e file al Hy othe vent,	BeC	17. Father's Name (First, Middle,	Last)		1	18. Mother's Name	(First, Middle, Ma	iden Sumame)				
Maryland	uld b Wenta	70	Pirley C. W	eeks				ginia A					
ar	sho and h sma	·	19a. Informant's Name/Relations	thip (Type, Print)	19b. Maili	ng Address (Street an	nd Number or Rural	Route Number, (City or Town, State, .	Zip Code)			
	and salth n 27		Laverne Huggin	s/Daughter_		O Natts Cr		-		20636			
altimore,	of He fiten		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from State		osition (Name of matory or other place)			c. Location - City or				
Ĕ	Pag nent ant: t ury o		'4 □Donation 5 □ Other (S			el Cemete				MD			
alt	Depar Import any in		21. Signature of Funeral Service	Licensee	2 2	2. Name and Address Brinsfie	of Facility 1d Funera	1 Home,	P.A.				
<u>m</u>	90F 9			101206/2/2	men	Leonardto	own, Mary	Land 20	650-02/9				
Ī			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that caused t only one cause on each lin	the death. Do not en	ter the mode of dying,	, such as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death			
Л	Physician		Immediate Cause (Final disease or condition		READIN	Alorus	Tarker	25		hal			
	/Medical		resulting in death)	Due to (or as a	a conseque de of):	1	~			/	•		
ķ.	Examiner		Sequentially list conditions,	b	The	usto	na			Wick			
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8760,	oe ex		,	Bue to (or as t	a consequence or,								
87	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Medical		d							_		
9 x	eath certific attending p	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy		-		23d. Date of de	ivery			
Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			Month Month	Day Year			
Ö	the de	yslc	1 ☐ Yes 2 ♠ No 9 ☐ Unknown	L Yes 2 MNO 9 I Inknown									
ص			Part II. Other significant conditi	ions contributing to death be	ut not resulting in the u	underlying cause giver	n in Part I.	23e. Did toba	cco use contribute to	the cause of death?			
ds,	es be	d by						1 🗆 Yes	2 3 No 3 □ P	robably 4 Unknow	'n		
Š	> 9 5	ete	Do	mentica				24a. Was an	24h Were a	utopsy findings availab	le		
Vital Records,	e lav has	ompleted	5	monuca	-			autopsy performe	prior to death?	completion of cause of	i		
a		C	GS Man and a state of the state of the				00 Plana (Dank	1 Yes 2	No 1 ☐ Yes	2 □ No			
₹		o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hospital:	-1 a T FB/Outrotio	Other	26. Place of Death		as C Other (See	ni6.)			
οţ	Phys r this ral di	-	1 Yes 2 No	1 ☐ Inpatie	ry 28b. Time o		-	8d. Describe how	ce 6 Other (Sperinjury occurred	city)	—		
	ding Ph h. After th funeral	tion	1 ØNatural 5 ☐ Pendi	Alanth Day	y Year) Injury		? es 2 □ No						
15	Attending or death. ector: Afte by the fune	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of Injuried	ury - At home, farm, st	treet, factory, office	2	8f. Location (Stre	et and Number or R	ural Route Number,			
27. Manner of Death 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1													
	Hospital or Att 24 hours after de Funeral Direct etely filled in by t	edical C		ng Physician: To the best of Examiner: On the basis of and manner sta	examination and/or in								
	To the Hos within 24 hd To the Fun completely	Me	29b. Signature and title of certifie		1) 1.	29c. License	number	290	I. Date signed (Mon	th, Day, Year)			
	NE		1	mail lbs	los Al	100	6419		9-6-	-225			
•	40		30. Name and address of person	who completed cause of d	eath (Item 23a) (Type	, Print)	- 11/		-				
	0		James P. Jarb	//	ree Notch		lvwood. M	D 20636					
	Sta	ate	31. Date filed (Month, Day, Year		ar's Signature	Land .							
	Regist	rar	े हार	S (FRAD)	on so	And the							

ZACHARY DAVID ONDRISH 05-06069 UNK.

> **Physicia** /Medica Examine

Funeral Director

Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, the Mudical Exacting an intuit of invittled at 2008.

Baltimore, Maryland 21215-0036

RJD

	Plea	ase Type or Pri	nt in Blac	k In	delible lnk. Ensure	All Copies A	Are Legil	ble.			
	1 - For Stete Registrar	State of M	aryland /		artment of Health and rtificate of Death		ene 0 0	5 3	30319		
	Decedent's Name (First, Midd	fle, Last)				2. Date of Death Month		Year	3. Time of Death		
an al	Zachary Dav						er 05,		0138 A. M		
er	4a. Facility Name (If not institution				4b. City, Town, or Location of Dea	ith	4c. County				
	Slasman Road (at t	Finksburg If Under 1 Year If Under 24 Hr		Carro				
	5. Social Security Number 219–23–7990 Usual Residence of Decedent	6. Sex 7. Ag 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ge (In yrs. last bi 16	Yrs.	Months Days Hours Mil		989	9. Birthplac Country Mary			
	10a. State 10b. Count	· · · · · · · · · · · · · · · · · · ·	10c. City, Tow	n or Lo	ocation			100	I, Inside City Limits		
ector	Maryland Carr	coll	Wes	ىنسن	nster		1 Yes 2 No				
ral Dire	10e. Street and Number 678 Blizzard F				10f. Zip Code 21157	g. Citizen of V					
Completed by Funeral Director	11. Marital Status 1 XNever Married 2 Ma 3 Widowed 4 Divorce	If Yes, Give	?		Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☑ No Specify:		e - Americar k, White, etc : Whit	с.			
npleted	15. Decede (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-4or		(Give	dent's Usual Occupation kind of work done during most of w DO NOT use retired)		bb. Kind of Business/Industry Westminster				
Sol	10	0		Stu	dent			igh School			
To Be	17. Father's Name (First, Middle Albert Joseph		• =			ame (First, Middle, M Lee Kirby	aiden Surnam	θ)			
	19a. Informant's Name/Relation M/M Albert J.				ng Address <i>(Street and N</i> umber or F Blizzard Farm Lar		-		ode) 1157		
	20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (cemete	ry, crei	osition (Name of matory or other place) Cremation Inc 9/		oc. Location -				
	21. Signature of Funeral Service	Licensee		41	ne & C	hapel, PA					
	23a. Part1. Enter the disease, t shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	A	pproximate hterval Between Inset and Death								
e	Sequentially list conditions,	b. Due to (or es	a consecuence	ut):							
Examiner	Cause, Enter Underlying Cause (Disease or injury that initiated events	С.									
	resulting in death) Last	Due to (or as	a consequence	quence of):							
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		23d. Date of delivery Month Day Year								
d by PI	Part II. Other significant condit	ions contributing to death t	out not resulting	in the u	nderlying cause given in Part I.				cause of death?		
Complete						24a. Was an autopsy perform	24b. V p ed? d	Vere autops rior to comp eath?	y findings available detion of cause of		
Be	25. Was case referred to medical examiner?	Hospital: 1 Inpati	ont 2 ED/O	utnet :		eath Check only one			(
2	1 ⊈Yes 2 No	1 🗆 Inpati	ent 2 LI EN/O	uthatier	nt 3 DOA Caler. 4 Nursing	Home 5 Resider	ice 6 Lighthe	r (Specify)	(scene)		

attending physiclen and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed by the within 24 hours efter death.

To the Funeral Director: After this certificete hes been six completely filled in by the funeral director. pege 2 should to

Physician /Medical Examiner

Medical Certification; To 29a. Certifier 29b. Signature and title of certifier

27. Manner of Death

1 Natural

3 Suicide

2 Accident

4 Homicide

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number O.C.M.E.

28c. Injury at Work?

1 ☐ Yes 2/5No

29d. Date signed (Month, Day, Year)

September 05, 2005

28f. Location (Street and Number or Rural Route Number, City or Town, State) FINKS BURG, ND

SYASITANAD & DIACKCTEER OF

OF CAR IN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

915105

ROAD

ANA RUBIO, MD 31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore Maryland 21201

28d. Describe how injury occurred

COUISION

PASSENGER

State Registrar

SEP 0 6 2005

5 Pending

investigation

6 Could not be determined



28b. Time of Injury

1:30 A

		-	For State Registrar		artment of Health and M tificate of Death	Reg	Z11115 3113Z11
	Physicia		1. Decedent's Name (First, Middle, Last) Patrick Daniel	O'Reilly		2. Date of Death	8.3. Time of Death 6:10 A M
	/Medic Examin	al	ta. Facility Name (If not institution, give street at 7612 Dew Wood Drive		4b. City, Town, or Location of Death Derwood		4c. County of Death Montgomery
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 M 2 0	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You Nov. 12,	
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	Maryli ef sho	tor	Maryland Montgomery	Derwood			1 ☐ Yes 2 🙀 No
	or 28e	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Country?
	ath w		7612 Dew Wood Drive	Decedest Firer in II S 12.1	20855 Was Decedent of Hispanic Origin? (Sp		ited States 14. Race - American Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I fleath and Mental Hygiene. Item 27 Is marked other than "neturel", or Items 23s or 28e-f show other treumatic event, II is Moraled Examiner must be notified at	by Funeral	1 Never Married 2 Married 1 ☐	ed Forces?	f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc. Specify: White
200	72 hou	eted	15. Decedent's Education (Specify only highest grade comp	leted) (Give	dent's Usual Occupation kind of work done during most of work	ina	b. Kind of Business/Industry
21215-0036	within lene. than	Completed		lege (1-4or 5+)	DO NOT use retired) YSicist	N	uclear Regulatory Commission
	e filed withir I Hygiene. other than ent, It e M	Be Co	17. Father's Name (First, Middle, Last)	'	•	e (First, Middle, Ma	
Maryland	2 should be f n and Mental H Is marked of reumatic eve	To B	Gabriel A. O'Re		Esther		
Mar	12 sho h and 7 Is mu treum		19a. Informant's Name/Relationship (Type, Prin		ng Address (Street and Number or Rur		
- -	Healt Healt tem 2	ΙÝ	Leona O'Reilly/ Wife 20a. Method of Disposition	20h Place of Dispo	Dew Wood Drive, D	Date 20	c. Location - City or Town, State
E C	nit. Pages partment of ortent: If it injury or injury or		1 ☐ Burial 2 【XCremation 3 ☐ Remova	from State Metropo Cremato:		st 31, 5 A	lexandria, Virginia
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is eny injury or other tre once.		21. Signature of Funeral S rvia Lionsee		2. Name and Address of Facility De 0 East Deer Park		ral Home, ithersburg, MD 20877
	Pnysician		23a. Fart of the the disease, or complications shock of hear billure. List only one caus immediate Cause (Final disease or condition	e on each line.	1 1	or respiratory arrest	Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death)		uyeloma		- 1
	LXammer	ē	Sequentially list conditions, b.	Due to (or as a cynsequence of):	agelona	44.60	/ nu ,
	uted	Examiner	Sequentially list conditions, and any leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
50,	cate be executed oblysician and the burial-transit	I Exa		due to (or as a consequence of):			
68760,	icate b physic s the b	dlca	d				
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Medical	in the past 12 months?		□Ectopic pregnancy □ Other (specify)	The second secon	23d. Date of delivery Month Day Year
<u>α</u>	uires that the de signed by the a	by	Part II. Other significant conditions contributing	ng to death but not resulting in the u	inderlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
Records,	he law requir e has been si age 2 should l	Completed				24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? No 1 9 yes 2 1 No
of Vital	sicien: The lar certificate has rector, page 2	BeC	25. Was case referred to medical examiner?			th (Check only one)	
) t	Physicien: this certific ral director,	2	Yes 2 No Hospita	1 Inpatient 2 ENOutpatie		ome 5 Resident	ce 6 Other (Specify)
on o	ding P h. After I	tion:	1 Natural 5 Pending	. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe now	injury occurred
Division	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	2 Thousand	. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	To the Hospitel within 24 hours of To the Funeral completely filled	edical C	(Check only 2 Madical Examinar: O	To the best of my knowledge, deat in the basis of examination and/or in id manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cau red at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
	To th Within To th compl	Me	29b. Signature and title of certifier		29c. License number		1. Date signed (Month, Day, Year)
	15			Jener. m.D.	D59013	A	ugust 31, 2005
	1		30. Name and address of person who complete			40 Paal	-1110 MD 20950
	St	ate	Konstantin Khludenev 31. Date filed (Month, Day, Year)	3. Registrar's Signature	lady Grove Kd., #1	40, KOCKV	TITE, MD 20000
	Regist		AUG 3 1 2005	39. Registrar's Signature			

			1 - For State Registrar	State of M	larylan		artment of H rtificate of L			giene 0 (5	30321		
	- 3		1. Decedent's Name (First, Middle, La	ist)					2. Date of De	ath		3. Time of Death		
	Physici /Medic		Mary Esther Post	ley					August	Day 31 2	Year 2005	2005 PM		
	Examin		4a. Facility Name (If not institution, given	re street and number)		4b. City, Town, or	Location of Death		4c. County of Death				
			Atlantic General				Berlin			Wor	cest	er		
	Funeral			Sex 7. A 1 □ M 2120 F	ge (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		th		place (State or Foreign		
	Director		221-09-2886 Usual Residence of Decedent	240		94 Yrs.			Nov 21			MD		
	and		10a. State 10b. County		10c. City	, Town or Lo	ocation				1	10d. Inside City Limits		
	Many f sh	to	MD Worces	ter	Bi	.shopv	ille					1 ☑ Yes 2 ☐ No		
	the r 28a	rec	10e. Street and Number				10f. Zip Code			10g. Citizen of V	What Cour	ntrv?		
	3a o	0	9303 Fooks Road				21813			U.S.		ŵ,		
	outs after death with the Manylan el', or Items 23a or 28a-1 show Exertinat fronti be rivilled at	Funeral Director	11. Marital Status	12. Was Deceden		S. 13.	Was Decedent of Hi	spanic Origin? (S	pecify Yes or No	- 14. Rac	14. Race - American Indian,			
ဖွ	after or Ite	F	1 Never Married 2 Married	Armed Forces 1 Yes 2 1 If Yes, Give			If Yes, specify Cuba 1 ☐ Yes 2 X No	n, mexican, Puero Specify:	o Hican, etc.)		ck, White, /: Blac			
03	ours ral,	d by	3 Widowed 4 Divorced	3 Widowed 4 Divorced Year or Dates:								CK		
5-(d within 72 hours piene. r than "natural", II a Medical Edi	Completed	15. Decedent's E (Specify only highest gr	ducation ade co <i>mpleted)</i>		(Give	dent's Usual Occupa	luring most of wor	rking	16b. Kind of Bu	usiness/In	dustry		
121	within ne.	mp	Elementary/Secondary (0-12)	College (1-4or	5+)	Labo	DO NOT use retired,)		D 7				
2	Hygie Hygie Ither t		17. Father's Name (First, Middle, Last)	18. Mother's Nan	no (Eiret Middle	Poul:							
auc	d be f ntal h ed ol	Be	Pete Williams	,							10)			
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Menial Hygiene. marked other than "natural", or Items 23a or 28a-f show imarked other than "natural", or Items 24a or 20a-f show imatic event, It is Medical Exercitival restriction.	户	19a. Informant's Name/Relationship	Type Print)		19b Maili	ng Address (Street a		ta Riley		State 7in	Cadal		
<u>8</u>	od 2 solith ar lith ar 27 is trau		Milford Postley/				56 Peerles		Bishopvi			·		
ē,	Hea Hea tem		20a. Method of Disposition		20b. PI	ace of Dispo	sition (Name of		Date	20c. Location				
JO L	ages ant of It: If i		1 Donation 5 ☐ Other (Speci		' C	urtis	matory or other place U.M.C.		/2005	Riche	oorri 1	lo MD		
Baltimore,	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, II a. M. once.		21. Signatura II Filment Lamice Lice		С	emeter 22	22. Name and Address of Facility							
ä	permi Depa Impo any ir		1000				Lewis N. 1618 West	Watson F	uneral	Home	201			
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	d the death	. Do not ent	ter the mode of dying	, such as cardiac	or respiratory ar	rest,	100	Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	AAI		100 tiv	Condition	103 culio	Disco	16. 4		Onset and Death		
	/Medical		resulting in death)	a. Due to (or a:	s a consequ	ence of):	00101101	1- vaccus	KIII	~		1 -43		
	Examiner		Sequentially list conditions	b										
	ק יִּדָּ	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequ	ence offic								
	and I-trans	cam	that initiated events resulting in death) Last	C										
8760,	cate be executed obysician and the burial-transit	Ē	Tooding in doding 2230	Due to (or as	s a consequ	ence or):								
87	cate ohys the	dicai		_ d							-			
2 V×	eath certifi attending I for use as	/Me	IF FEMALE:	23c. If yes, outcome	e of pregnar	nev								
7.5 80 80 80 80	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal	déath 3□	Ectopic pregnancy Other (specify)			23d. Dat Mor	e of delive nth	ory Day Year		
- 0	0 0	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	it time or de	alli J	J Other (specify)							
200	that the	y Ph	Part II. Other significant conditions	contributing to death	but not resu	lting in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use conti	ribute to th	ne cause of death?		
g & g	law requires that the as been signed by th 2 should be detache	d by							1 🗆 Y	′es 2□No	3 🗀 Prob	ably 4 Ninknown		
- IOS	w requi	Completed							24a. Was	an 24b. V	Vere autor	psy findings available		
Se.	9 4 9	Juc							autop perfo	rmed?	rior to cor leath?	npletion of cause of		
ta a	ician: Th certificate ector, pag	0	25. Was case referred to medical					26. Place of Dear			Yes	2 No		
3 42	ysicia is cer direct	0	examiner? 1 Yes 2 No	Hospital:	ent 2 🗆 E	ER/Outpatier	nt 3 DOA Othe	4 Nursing H			er (Snacifi	()		
Z 50	ra th	n: T	27. Manger of Death	28a. Date of Inj (Month, Da	ury	28b. Time o	28c. Injury Work	at		ow injury occurr		,		
<u>\$05</u>	Attending r death. ector: After by the fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		ay rear/	Injury		es 2 □ No						
Nis Vis	l or Atte after de Directo I in by th	3 Suicide 4 Homicide 1 See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28 Description (Street and Number or Rural Route building, etc. (Specify)										l Route Number,		
्र देशें	spital or /	Certification:		building, o					ony or ron	ii, otato)				
	To the Hospital within 24 hours a To the Funeral I completely filled	cai	(Check only 2 Madical Exa	nysician: To the best miner: On the basis	of my know	riedge, deati	occurred at the tim	e, date and place,	, and due to the o	cause(s) and mai	nner as st	ated.		
	To the Hos within 24 h To the Fur completely	Medical	Olie)	and manner s	tated.									
	To With	<	29b. Signature and little of certifier	1. 1	,	-	29c. License	number		29d. Date signed	(Mpnth, I	Day, Year)		
	-03		14 V 016	well	L-	h-	0 10	0/61		TIL	10	>		
	00		36. Name and address of person who	completed cause of	death (Item	23a) (Type,	Printy Jan 1	Has.	Fo.	+ Iclo.	11	De 19944		
	-0	10	31. Date filed (Month Day, Year)	32. Partiet	rar's Signati	Tan (Jus	1 auc	0 -17 000	6	11114		
	Sta Registr		SEP 0'6	2005	rar's Signati	H. 1	barle							
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State of Maryland / Department of Health and Mental Hygiene Beg. No. 005 30322 For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death 11:50 Å Sept. Day 2005 **Physician** 1, Glenn Pruett, Jr. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LaPlata Charles Charles County Nursing & Rehab If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1923 9. Birthplace (State or Foreign Country) TN5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1**7** M 2□ F 413-24-9081 82 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d Inside City Limits 289-f ehow the Medical Exemples must be notified at 1 ☐ Yes 2 📉No MD Director Charles Pomfret 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 20675 itе те 23a USA 4443 Bellwood Drive death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Aes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Menial Hygiana. Important: If item 27 Ie marked other then "natural, or item eny injury or other treumatic event, the Mudical Exemples once. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Ceramic Engineer Private Industry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harry Glenn Pruett Tressie Mae Ice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Kay George/Daughter 4443 Bellwood Dr. Pomfret,MD 20675 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols 9/2/05 Charlotte Hall, MD 21. Signature, of Funeral Service Licensee ²²AREHAKTSECHOLS FUNERAL HOME, P.A. M00945 . Ehul P.O. BOX 567, LA PLATA, MD 20646 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Preumonia

Due to (or as a consequence of): **Physician** 3 days termina disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine anding physician and usa as the burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) has been signed by the a ge 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?
1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? Cancer certificate 1 TYes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 25 No Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) After thi funeral of 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Injury s after dea. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide To the Hospitel o within 24 hours aft To the Funerel DI: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 5625 All 32. Ribistrar's Signature Fatima Allertown Rd. #101, CampSprings, MO 20746 HUSSRIN 31. Date filed (Month, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 5 30323 For Stata Ragistrar Certificate of Death Reg. No 2. Date of Death 1 Decedent's Name /First_Middle_Last) 3. Time of Death Aug. 28, 2005 **Physician** Prince Jr. Charles Kendall 5:00a M /Medical 4a. Facility Name (If not institution, give street and number)
8421 New Hampshire Avenue 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hyattsville If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months 578-48-4222 Days Hours 10X M 2 □ F wash. D.C. 68 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show itam 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic avant, Ite Maxical Exx. Ther is ust be natified at Hyattsville Prince George's 1 ☐ Yes 2 ☐ No MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1 20783 USA 8421 New Hampshire Avenue Completed by Funeral iled within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Specify White 1 ☐ Never Married 2 ☐ Married 1957 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) at Hygiene. College (1-4or 5+) 5 + Elementary/Secondary (0-12) Self Employed Dentist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be find Mental I Hazel Jean Cleavland n and Mental Charles Kendall Prince, Sr. 19a. Informant's Name/Relationship (Type, Print)
Lori Prince/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co2e) 783 Pages 1 and 2 s nent of Health an 8421 New Hampshire Ave. Hyattsville, Md Department of Health a Important: If itam 27 is any injury or othar tra once. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Chesapeake Crem 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 8/31/05 Beltsville, Md ° 4 □ Donatio 5 Other (Specify) 21. Signatur Funeral Service Licensee 22. Name and Address of Facility PHILIP D.RINALDI Functal Service, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter I've disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer of Esophagus **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner -transit The law requires that the death certificate be executed Due to (or as a consequence of): burial P.O. Box 68760, physician Physician/Medlcal the IF FEMALE esr. yes, outcome of pregnancy □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 1 Live birth Month Day Year ğ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed 1 Yes 2 ☐ No 2X No Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) Hospital: 2 1 🗌 Yes 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Atter Hospital or Attending 5 Pending investigation s after dec. 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Vithin 24 hours are.

To the Funeral Dir 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Aug. 30, 2005 D23743 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Martin Weltz MD 7525 Greenway Ct. Greenway Ct. Greenbelt, Md 20770 31. Date filed (Month, Day, Year) 32/Registrar's Signature State SEP 01 2005 BOUR Registrar

			1-	For State		State of	Maryl	and / Dep <i>Ce</i>	artment of <i>rtificate of</i>	Heali Dea	th and M ath	lental Hy	gien	005	5	303	324
	G		1. D	Registrar ecedent's Name	(First, Middle, L				Timoato of	200	4177	2. Date of De	ath	,.			of Death
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	Examin		4a.	Facility Name (If	not institution, g	ive street and numb	oer)		4b. City, Town,	or Loca	tion of Death		40	. County of	Death		<u> </u>
					lder Way				Annar			,		Anne A			
	Funeral		5. S	ocial Security Nu		Sex 7. 1 □ M 257F		vrs. last birthday,	If Under 1 Yea Months Days	Months Days Hours Min. (Month, Day, Y					Count	try)	or Foreign
	Director		Usu	061-05- al Residence of		Λ	9	1	June 13,					1914	New	York	τ
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If tiern 27 is marked other then "neturel", or items 23e or 28e-f show importent: If tiern 27 is marked other then "neturel" or other treumetic event, If a Modical Exercit at a state notified at once.			. State	10b. County		10c.	City, Town or L	ocation				_		10	Od. Inside	City Limits
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	or 28	Oire	10e	. Street and Num	nber				10f. Zip Code				10g. Ci	tizen of Wha	it Count	try?	
	ath w	Funeral Director			lder Way						1401			USA			
	Items	nue		Marital Status 1 Never Marrie	ad 2 Marriag	12. Was Deced	002	n U.S. 13.	Was Decedent of If Yes, specify Cu	Hispani ban, Me	c Origin? (Sp xican, Puerto	ecity Yes or No Rican, etc.))- 	14. Race - Black, V	Amenca White, 6		
336	urs aft	by F		3 X XVidowed		1 Tes 2 If Yes, Give Year or Date	es:		1 ☐ Yes 2X No	Spe	ecify:			Specify:	1	White	:
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フェース Table 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sum										n Sumame)	Sumame)						
Ž	2 should be filed withlic and Mental Hygiene. Is marked other then eumetic event, Ire M.	Louis Jones Rose Becker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State											ate. Zio	Code)			
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Baltimore,	permit. Pag Department Importent: eny injury o		21.	Signature of Fur	neral Service Lic	ler de		2	2. Name and Add Hardesty	7 Fui	neral 1	Home, P	.A.				
	40300		23	a Parti Enter th	ya disaasa or co	mplications that cau	used the c	leath. Do not en	12 Ridge					, MD	2140	O1_ Approxim	ato
				shock, or hear mediate Cause (rt failure. List on	ly one cause on each	ch line.	/	D	ring, sac	ii as caraiac	or respiratory a	.11031,		_	Interval B Onset and	etween
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	certific nding p			FEMALE: b. Was decedent	progrant	23c. If yes, outco	ome of pre	gnancy						23d. Date o	f delive	rv	-
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E E	Physicien: The lav this certificate has al director, page 2	Cor										1 ☐ Yes	med?	dea 1 🗆	Yes	No	
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	Sta Regist		31.	Date filed (MON)	AUG 3	2005	Surai S S	ignaturo A	Shoult a								- 1

State of Maryland / Department of Health and Mental Hygiene 2005 1 - For State Registrar 30325 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** WILLARD PRATT AUGUST 29, 2005 2:35 PMM /Medical 4c. County of Death CARROLL 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WESTMINSTER WESTMINSTER NURSING/REHAB CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs, last birthday) 6 Sex 9. Birthplace (State or Foreign **Funeral** 1**½**M 2□ F Days 219-20-6207 81 KENTUCKY Director MARCH 24,1924 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County show in then "natural", or Itema 23a or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2XXIo FINKSBURG MARYLAND CARROLL Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with UNITED STATES 21048 2151 BALTIMORE BLVD. death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1√DYes 2 ☐ No If Yes, Give 14. Race - American Indian. Black, White, etc. s 1 and 2 should be filed within 72 hours after af thealth and Mental Hygiene.
Itam 27 Is marked other then "natural", or Ite X□Never Married 2□ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TRUCK MACHINIST TRANSFER COMPANY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be CHARLES PRATT SYMTHA MARY ADAMS ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAULINE WALLACE - SISTER 2151 BALTIMORE BLVD, FINKSBURG, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST VETERANS CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
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any injury or ot ¶ Burial 2 ☐ Cremation 3 ☐ Removal from State OWINGS MILLS, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
MYERS-DURBORAW FUNERAL HOME, P.A. لعا 11110 91 WILLIS STREET, WESTMINSTER, MD 21157 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Severe Immediate Cause (Final ease or condition resulting in death) Dementa 2 years Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical the r IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death P.O. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Minown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ ★6 24a. Was an autopsy performed? 1 ☐ Yes 2 **N**o 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. 27. Manner of Death 28d. Describe how injury occurred Phospital or Attending Post Abours after death.
Funeral Director: After the 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO 30 2005 MJL el 2+1VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stoner CHACK 31. Date filed (Month, Day, Year) 32. Reastrar's Signature State Registrar 2005

State of Maryland / Department of Health and Mental Hygie 0 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** SEPTEMBER 201015 1:14 Beverly Claire Pace /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution give street and number) 4b. City, Town, or Location of Death Examiner | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan. 27, 1935 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 200 70 Illinois Director 346-26-2107 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or Iteme 23s or 28s-1 show the Madical Examinar must be notified at 10d. Inside City Limits Director 1 Yes 2 No Florida Brevard Merritt Island 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4795 Pawnee Trail 32953 U.S.A. Completed by Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Controller .. Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: If item 27 is marked other t ijury or other traumatic event, ID Oil Company 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame, Vernon Geib Dorothy F. Giermann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Baublitz 18 Poplar Grove Ave. Aberdeen, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment o Important: If any injury or once. R. A. Ferris & Co. 9/2/05 West Chester, PA 21. Signature of Foreral Service Licensee Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OCCLUSION LEFT CORONARY ARTERY **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law réquires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. physicien Be Completed by Physician/Medical be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETES MELLITUS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? PERIPHERAL VASCULAR DISEASE 24a. Was an page 2 autopsy performed? Yes 2 No 1 Yes 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending Injury safter death.

I Director: Af
d in by the fur 1 Yes 2 No 2 Accident investigation 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide o the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signature and title of ertifier 29c. License number 29d. Date signed (Month, Day, Year) Colomo M D0018406 9-2-0 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7505 OSLER DRIVE TOWSON, MARYLAND 21204 FRANK MORRIS M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 7 2005 Registrar

		For State Registrar	State o	of Maryland	l / Depa <i>Cei</i>	artment of H	lealth a Death	and Ment	al Hygi	ere 0	05	30327
Physicia	an	Decedent's Name (First, Middle JASON WALTER		R.				M	ate of Death onth GUST	Day 26	2005	3. Time of Death 8:35AM M
/Medic Examin		4a. Fecility Name (If not institution				4b. City, Town, or	r Location (OODI		ty of Death	TACC.0
Lxaiiiii		CORSICA HILLS	NURSING	CENTER		CENTRI				QUE	EN ANN	E'S
Funeral		5. Social Security Number	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min. (M	te of Birth lonth, Day,	Year)	Coun	lece (State or Foreign ltry)
Director		216-34-7605 Usuel Residence of Decedent		68	110.			DEC	3. 9,	1930	NC	
how		10a. State 10b. County		10c. City,	Town or Lo	cation					1	Od. Inside City Limits
8a-f s	ecto		ANNE'S	GRA	SONVI							1 ☐ Yes 2 X No
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or ite	F.	1 Never Married 2 Marri	ied 1 X Yes If Yes, Gi	2 No 1950	6	f Yes, specify Cuba 1 □ Yes 2 X No	Specify:		, etc.)	Spec	lack, White,	өтс. ITE
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and 2 s lith an 27 ie i r traui		DAWN THOMAS/DAI				POSTAL R				2161	_	
of Hear item		20a. Method of Disposition		CO	ace of Dispo	sition (Name of natory or other place	ce)	Date	-	20c. Location	n - City or To	wn, State
Page ment ent: II		1 ☐ Burial 2 🕱 Cremation '4 ☐ Donation 5 ☐ Other (S)		Ulle	SAPEAR TER, 1	E CREMAT	ION	08/31/20	005	STEVE	NSVILI	LE, MD
permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tra		21. Signature of Puneral Service	Licenson	hon.	FI	Name and Addrese ELLOWS, H O6 SHAMRO	ELFEN	BEIN &	NEWNA	M FUN	ERAL B 21619	IOME, P.A.
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leath certifica attending ph	n/Me	IF FEMALE: 23b. Was decedent pregnant		itcome of pregnan		75				23d. D	ate of delive	ry
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la		30. Name and address of person AND (row)	1 1 1	se of death (item	23a) (Type,	Print) Imman's L	lan	, Eass	6n, 1	UD.	2160)	/
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State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

		1 - For State Registrar	State of Man	•	artment o			Reg. 9. 115	30328
Physici /Medio Examin	cal	Decedent's Name (First, Middle, Last) Carrol Pattison 4a. Facility Name (If not institution, give s			4b. City, Tow	m, or Location of Dea	2. Date of D Month 08	Day Yea 27 2005 4c. County of De	6:52 A M
Funeral Director		221 42 3303		Center on yrs. last birthday) Yrs.	If Under 1 Y	n, Maryla ear If Under 24 Hr ays Hours Mir	S. 8. Date of B		Porges inthplace (State or Foreign Country) Ktown , PA
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. itam 27 is marked other than "natural", or itams 23a or 28a-1 show other traumatic avant, the Medical Example traumatic avant, the Medical Example traumatic avant.	ector	Usual Residence of Decedent 10a. State 10b. County MD Prince Ge 10e. Street and Number		Oc. City, Town or Lo	ocation 10f. Zip Coo	40		100 Citizen of Whee	10d. Inside City Limits 1 X Yes 2 ☐ No
death with t	by Funeral Director	6101 Wesson Drive	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	2074		Specify Yes or N	USA	nerican Indian,
hours after itural, or its	ed by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣	No Specify:	ito rican, etc.)	Black, Wh	ite
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should be file of Mental Hy marked oth matic avan	To Be	17. Father's Name (First, Middle, Last) Howard Martin Orno 19a. Informant's Name/Relationship (Ty,		19b. Maili	na Address (St	Esther	Throne	e, Maiden Sumame) ber, City or Town, State	Zio Code)
es 1 and 2 s of Health ar f itam 27 ls r other trau		Cindy Pattison/Da 20a. Method of Disposition 1 Surial 2 Cremation 3 DR	ughter	610] 20b. Place of Dispo cemetery, crea	L Wessel osition (Name of matory or other	Drive Su	uitland,	MD 20746 20c. Location - City of	
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Physician /Medical		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	e death. Do not en	ter the mode of	dying, such as cardi		arrest,	Approximate Interval Between Onset and Death
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v requires that the death certific been signed by the attending p should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregna □ Other <i>(specif</i>)			23d. Date of d Month	elivery Day Year
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To the Hospital or Attandwithin 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)	reet, factory, off	ice	28f. Location City or To	(Street and Number or Fown, State)	Rural Route Number,
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. (4)	ate	30. Name and address of person who to the second of the se	Patel (NO 75	701 SU	ursatts f	ed (inton m	D 20735

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Marylan	•	artment of H				ne 0 0)5	30329
	o Physici	an	Decedent's Name (First, Middle, La. ALBERT	st)	PALLIA				2. D	eate of Death Month	Day	Year	3. Time of Death
}	/Medic Examin		4a. Facility Name (If not institution, give	street and num			4b. City, Town, o	or Location of		1021 2/	4c. County		9:20 AM M
	:		2820 DURMONT COUR					POLIS			ANNI	E ARU	
	Funeral Director		5. Social Security Number 6. S 578-58-1276	ex ⊋M 2□F	7. Age (In yrs. I. 85	ast birthday) Yrs.	Months Days	If Under Hours		ate of Birth Month, Day, Y	^(ear)	9. Birthi Coul EGY	
	D		Usual Residence of Decedent 10a. State 10b. County			. Town or Lo					.,,,,,		
	Manyla f shov	ō	10a. State 10b. County MARYLAND ANNE ARU	NDET		v, Town or Lo NAPOLI							10d. Inside City Limits 1 1 Yes 2 ☐ No
	r 28a-	irect	10e. Street and Number	NDEL	AIV	NATOLI	10f. Zip Code			10g	. Citizen of V	Vhat Cou	ntry?
	23a c	raiD	2820 DURMONT COUR	Т			21401				UNITEI	STA	TES
9	be filed within 72 hours after death with the Maryland hat Hygiene. Id other than "natural", or items 23a or 28a-1 show event, the Medical Examinar must be notified at	/ Funeral Director	11. Marital Status 1 □ Never Married 2X Married	12. Was Deced Armed For 1 ☐ Yes If Yes, Give	ces? 2 🕅 No		Vas Decedent of H fYes, specify Cub I□Yes 2X No	an, Mexican	i, Puerto Ricar	Yes or No- n, etc.)		k, White,	
21215-0036	hours tural', al Exe	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Da	tes:		lent's Usual Occur			1.0		WHI	
75	nin 72 In "na Medic	Completed	(Specify only highest gra		40r 5+\	(Give	kind of work done OO NOT use retire	during most	t of working	10	b. Kind of Bu	isiness/in	dustry
7	filed with Hygiene Ither the	Com		2	10, 0.7,	EX	ECUTIVE	1					EMICAL
Baltimore, Maryland	12 should be filed w n and Mental Hygie 1s marked other t raumatic event, In) Be	17. Father's Name (First, Middle, Last) ELIE PALL						er's Name <i>(Firs</i> REGINA		iden Sumam ABRAM	10)	
aryl	es 1 and 2 should b of Health and Ments fitem 27 is marked r other traumatic e	To	19a. Informant's Name/Relationship (19b. Mailin	g Address (Street					State, Zip	Code)
Σ,	and 2 ealth a m 27 li		DORA PALLIA, WIF	E			DURMONT	COURT					
Jore	iges 1 if iter or off		20a. Method of Disposition 1X Burial 25 Cremation 3 □		tate Ce	emetery, cren	sition (Name of natory or other pla	- 1	Date		c. Location -	-	
Ħ,	permit. Pages 1 Department of H Important: If ite any injury or oti		* 4 □ Donation /5 □ Other (Specify 21. Signature of Juneral Service V er	/_/	MT.		ON CEMET	and the second second	The second second				IARYLAND
ä	permit Depar Impor any in		1 favest V	Tro	ث	10	Name and Addre WARD SAG 91 ROCKV	EL FUN ILLE E	NERAL D PIKE, R	IRECTI OCKVIL	ON, IN LE, MD	C. 20	852
			23a. Part). Enter the disease, or com shock, or heart failure. List only							oiratory arrest	t,		Approximate Interval Between Onset and Death
þ	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a			RANIAL P	RESSU	RE				Onset and Dodin
	Examiner			BRA	oras a consequ IN META								
	p #	iner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury		r as a consequ HODGKI		DHONA						
_	xecute and al-trans	Examiner	that initiated events resulting in death) Last	C	or as a consequ		IIONA					-	
8760,	cate be executed physician and the burial-transit	dicai E		. d.									
9	ertifica ling ph e as th	Medi	IF FEMALE:								1		
Box	eath certif attending for use a	Physician/Me	23b. Was decedent pregnant in the past 12 months?		ome of pregnar th 2 ∐ Fetal .nt at time of de	death 3	Ectopic pregnanc	y			23d. Dat Mor	e ol delive nth	ery Day Year
Ö	tthe de by the a	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknov									
ds, P	as tha	ρ	Part II. Other significant conditions of	ontributing to dea	ath but not resu	ılting in the ur	iderlying cause giv	en in Part I.				ibute to ti 3 ☐ Prob	ne cause of death?
Records,	w require s been si should I	Completed								4a. Was an			psy findings available
	The fav	omb								autopsy performe Yes 2		rior to colleath?	mpletion of cause of
Vital	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?	La Company					of Death (Che		3140		20,10
of	Phys this ral dii	- L	1 ☐ Yes 2 🛣 No	Hospital: 1 □ In 28a. Date of		ER/Outpatien	3 □ DOA Ott	4 🗀 14u	rsing Home	5 Fesidence Describe how			y)
<u>o</u>	Attending I r death. ector: After by the funer	ation	1 Natural 5 Pending 2 Accident investigation	(Month	, Day Year)	Injury	Wor	k? Yes 2⊟!		70001100 11011	injury occurr	64	
Division	Dir te	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	286. Place	of Injury - At hor g, etc. (Specify	me, farm, stre	eet, lactory, office		281. L	ocation (Stree City or Town, S	et and Numbe State)	er or Rura	l Route Number,
troid	spital ours heral filled		29a. Certifier 1 Certifying Ph	ysician: To the t	pest of my know	wledge, death	occurred at the tir	me, date an	d place, and d	ue to the caus	se(s) and ma	nner as s	tated.
	To the Hos within 24 h To the Fur completely	Medicai	(Check only 2 Medical Exam	nner: On the bas	sis of examinat	ion and/or inv	estigation, in my c	pinion, deal	th occurred at	the time, date	and place, a	ind due to	the cause(s)
	with To T	Σ	29b. Signature and title of certifier	-//		4. ^	29c. Licens	e number	21	29d.	Date signed	(Month,	Day, Year)
7	10		30. Name and address of person who	completed cause	of death (Item	23a) (Type	Print)	753	06		0/2	870	5
_			0 1-11.	mo 90	U Be	5/94/	, le	sto 3	suo An	nepul	is un	10	1401
:-	Sta Registr		31. Date liled (Month, Day, Year) AUG 3 1 20	32 Re	gistrar's Signat	ure do	29c. Licens						,
	· Hegisti		YOU OT TO	No.	1000 00	-							

			For State Registrar	State of N	Marylan	•	artmen tificate			and Me	_	giene Reg. No.	005	30330
	Physici		1. Decedent's Name (First, Middle Alquimeres Loyo		2						2. Date of De Month AUGUST	Day 29	9, 2ŎÖ5	3. Time of Death 11:20A. M
	/Medic Examin		4a. Facility Name (If not institution, 9601 SEVEN LOCK		r)			Town, or HESD	Location o	of Death			County of Dea	
	Funeral Director		5. Social Security Number none	6. Sex 1 M 2 ☐ F	Age (In yrs. 53	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birl (Month, Da 06-21-	h V. Year) 1952		thplace (State or Foreign buntry) a, Peru
	aryland ehow	2	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation ver Sp	rino						10d. Inside City Limits 1 X Yes 2 □ No
	or 28a-f	Directo	Maryland Montgo			DIIV	10f. Zip	Code					en of What Co	
36	t within 72 hours after death with the Maryland liene. r then "naturel", or Iteme 23a or 28a-f ehow the Mudical Examana must be notified at	by Funeral Director	13210 Clifton Ro 11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Deceder Armed Forces	ş? No		Was Deced f Yes, spec 1X Yes		spanic Origin, Mexican	gin? (Spec i, Puerto F Perua	cify Yes or No Rican, etc.)		u 4. Race - Ame Black, Whi Specify: W	e, etc.
Maryland 21215-0036	within 72 hou iene. 'then "nature ite Medical E	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education It grade completed) College (1-40	r 5+)	life. i	dent's Usua kind of wor DO NOT us	rk done d se retired)	uring mos	t of workin			and Ha	
and 2	be filed tal Hyg d othe event,	To Be C	17. Father's Name (First, Middle, I								(First, Middle,		,	aredes
Mary	12 sh h and 7 le m treum	F	19a. Informant's Name/Relationsh broth Johny Andres Ca	nip (Type, Print)		12337 Germa	Quai	(Street a	nd Numbe	or Aurai Drive	Route Numbe			
Baltimore,	of H		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp	3 Removal from State	te C	Place of Disponentery, crematery, Crematery	sition (Nan natory or o	ne of ther place	9)		ate		ation - City or	
Baltin	permit. Page Department of Important: If eny Injury or once.		21. Signature of Funeral Service I			22	. Name an	d Addres	s of Facilit	ιyW.Η. N.W.	Bacon Wash.,	Fune	eral Ho	me, Inc.
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that caus	ed the deat	th. Do not ent					respiratory ai		10	Approximate Interval Between Onset and Death
,092	/Medical Examiner hysicien and prinal-transit	ical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a		quence of):								·
Box 68	death certificat e attending phy d for use as th		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon			Ter .					2	3d. Date of de	livery
o	0 0 0	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	at time of c]Ectopic pr] Other (sp						Month	Day Year
rds, P	quires the	þ	Part II. Other significant condition	ns contributing to death	but not res	sulting in the u	nderlying c	ause give	n in Part I.			obaccous /es 215		o the cause of death? robably 4 Unknown
al Records,	: The law requires thet the cate has been signed by the page 2 should be detache	Completed		~						-	24a. Was autor perio 1 Yes	sy rmed?	24b. Were a prior to death?	utopsy findings available completion of cause of
of Vital	Physician: This certificated director, p	To Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpa	atient 2	ER/Outpatier	nt 3 DC	Othe	Ar-		(Check only only one 5 ☐ Residue)		(Specifical)	city) SCENE
ion of	ding h. After fune		27. Manner of Death 1. Natural 5 Pendin 2 Accident investig	28a. Date of Ir (Month, I		28b. Time o Injury		8c. Injury Work		2	8d. Describe I			VII)
Division		Certification;	3 Suicide 6 Could r 4 Homicide determ	ined 288. Place of	Injury - At h etc. <i>(Speci</i>	ome, farm, str	eet, factory	y, office		2	8t. Location (3 City or Tox			ural Route Number,
	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	Medical (g Physician: To the basis Examiner: On the basis and manner	of examina									
	To the within 2	Σ	29b. Signature and title of certifier	1/1/1	M		290	c. License					signed (Mon	
2	(3)		30. Name and address of person	who completed and o	of death (Ite	m 23a) (Type,			STRE		LTIMOR		ST 30,2 RYLAND	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) SEP 0 2 2	1/	strar's Sign	ature								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygie 20 0 5 30331 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** LOUIS CHARLES ROSENBERG SEPTEMBER 6,2005 8:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL WESTMINSTER CARROLL HOSPITAL CENTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) OCTOBER 31, 1948 5. Social Security Number 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) **Funeral X**X ^M 2□ F Months MARYLAND 216-48-0359 56 **Director** Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours atler death with the Marylar nent of Health and Mental Hygiene.
ant: if item 27 is marked other than "naturel; or titems 23c or 28a-f show up or other than the rodified at ury or other treamstic event, the Nucleal Exam are made to rodified at tynes 2 □ No WESTMINSTER Director MARYLAND CARROLL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21157 UNITED STATES 398 SOUTH BISHOP STREET by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes XXNo If Yes, Give 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: WHITE If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALES/MARKETING RADIO /TELEVISION 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be FREDA SPUNGIN HYMAN OTIS ROSENBERG 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RUTH ANN ROSENBERG/WIFE 398 SOUTH BISHOP STREET, WESTMINSTER, MD 20a. Method of Disposition
XX Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State perrit. Pages 1 Dep rtment of H Importent: If ite any injury or ot or a. LEISTERS CHURCH CEMETERY 9/9/2005 WESTMINSTER, MARYLAND 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
MYERS-DURBORAW FUNERAL HOME, P.A. 21. Signatur of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21157 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ation **Physician** /Medical Due to for as a consequence of): inferc **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9☐ Unknown detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 □ Yes 2 7 No Division of Vital completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Hospitel or Attending 24 hours after death. 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide To the Hospitel within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suspeci (Anth Dring ushner June 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 005 30332 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** REBERT 7:30AM SEPT 1855e OWINGS 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CARROLL 152 LEISTERS CHURCH ROAD WESTMINSTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) 1, 1916 MARYLAND **Funeral** XX M 2□ F Months Days Min. Hours 213-32-5586 88 Yrs Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show traumatic avant, the Medical Examiner must be notified at 1 ☐ Yes 2 📆 No Director WESTMINSTER MARYLAND CARROLL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 21157 UNITED STATES 152 LEISTERS CHURCH ROAD Items 23a death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If itam 27 is marked other than "natural", or Iter 1 ☐ Yes 2 XXo If Yes, Give Year or Dates: 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: Completed by WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) SUPERVISOR DAIRY FARMING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CLAUDE VERNON REBERT ALICE ESTELLA OWINGS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) itam 27 i E. DORIS REBERT/WIFE 152 LEISTERS CHURCH RD, WESTMINSTER, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 9/06995 Department of Important: If it any injury or o X Burial 2 ☐ Cremation 3 ☐ Removal from State JOHN (LEISTERS) CEMETERY WESTMINSTER, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MYERS-DURBORAW FUNERAL HOME 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. WESTMINSTER, MD 21157 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARTERIOSCUEROTIC CORONARY DISEASE Pnysician VASCULAR /Medical Due to (or as a consequence of): 25 years **Examiner** HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to ful as a consequence of i. Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Ö the 9 Unknown 9 Unknown ۾ ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 2XNo 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tyes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; After Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 \ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29c. License number 29b. Signature and title of certifier ATTENDING WIL PHYSICIAN mod 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) U 904 WASHINGTON RD UESTMINST ARTHUR 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 06 Year & Spark 2005 Registrar DHMH 17 Rev 1/200

ORIGINAL

State of Maryland / Department of Health and Mental Hygie 2e0 05 30333 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year September 06, 2005 Leona Ruth Rae **Physician** 10:30 A. M /Medical 4c. County of Death Allegany 4b. City, Town, or Location of Death Frostburg 4a. Facility Name (If not institution, give street and number)
14201 New Georges Creek Road **Examiner** If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 X F 212-38-6096 83 February 17, 1922 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits , or items 23a or 28a-f show an instroust be notified at Allegany Frostburg Maryland 1 ☐ Yes 2 No Director 10g. Citizen of What Country? U.S.A. 10e. Street and Numbe 10f. Zin Code 14201 New Georges Creek Road 21532 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status traumatic event, the Madical Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after rans of Health and Mental Hygiene.
ant: if Itam 27 ie marked other than "natural", or Itel ury or other traumatic event, IT's Madical Estarinar ury or other traumatic event, IT's Madical Estarina. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Baltimore, Maryland 21215-0036 Specify: Specify Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) Alice Scollicky 17. Father's Name (First, Middle, Last) Be Robert Russell 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene Winkler 13506 New Georges Creek Road, Frostburg, Maryland 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition September 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Lonaconing, Maryland Department of Important: If any injury or once. St. Mary's Catholic Cemetery 10, 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home 8 East Main St., Lonaconing, MD. 21539 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death the Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 Tyes 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy certificate 2 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one examiner' Other: 4 Nursing Home 5 A esidence 6 Other (Specify) 1 Yes 2 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Beath 28b. Time of 28d. Describe how injury occurred After t Injury 1 Natural 5 Pending death. 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral D 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manger stated. 29b. Signature and title of certifier Walsh Drive, Cumberland, MD 21502 30. Name and address of person who completed can e of death (Item 23a) (Type, Print) State Registrar

		1	For State Registrar		State of N	Marylan	id / Depa	artmen <i>rtificat</i>	t of H	ealth a Death	and M		giene Reg. No.	005		30334	ł
			Decedent's Name (First, Middle	e, Last)								2. Date of De	eath			3. Time of Death	1
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yeici	is cer direct	To Be	examiner? 1 ☐ Yes 2 ☑ No	-	ospital: 1 Inp	atient 2	ER/Outpatie	nt 3 🗆 D0	OA Othe	ar		me 5 Resi		☐Other (S	Specify)		
O F	ector: After this certificate haby the funeral director, page	Ľ:	27. Mann of Death 1 Natural 5 ☐ Pendi	0.0	28a. Date of I	njury Day Year)	28b. Time o	of :	28c. Injury Work	at c?		28d. Describe	how injury	occurred			
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Division of all or Attending Phy after death.	Direct in by	Certification:		nined	28e. Place of building	Injury - At h , etc. <i>(Speci</i> i	ome, farm, st fy)	reet, factor	y, office			28f. Location (City or To	(Street and wn, State)	Number oi	r Rural i	Route Number,	
spital ours	filled		29a. Certifier 1 Certifyi	ng Phys	ician: To the be	est of my kno	owledge, deat	th occurred	at the tim	ne, date an	nd place.	and due to the	cause(s) a	nd mannei	r as stat	ed,	
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To th within	To th	Me	29b. Signature and title of certific	br O				29	c. License	number			29d. Date	signed (M	onth, Da	ay, Year)	
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1	6		30. Name and address of person	who cor	npluted cause	of death (Iter	m 23a) (Type		- (0 -	1	1	0.0				
7	10		21 Date filed (Month Day Year	<u>- D</u>	0101,1	strar's Signa		arle	m &	none	Dri	re, La	lish), m	D2	1801	
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Thomas Ryan 155-18-8685

State of Maryland / Department of Health and Mental Hygie 10 5 30335 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Hope Florence Fowler Reeves September 7, 2005 12:25 a.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Mary's St. Mary's Nursing Center Leonardtown If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🖾 F Months Director 80 Nov. 14, 1924 New York 074-18-8376 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Y☐Yes 2☐No Directo Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21585 Peabody Street 20650 <u>United States</u> Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2♥ No If Yes, Give A 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Director Water/Sewer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wilbur Fowler Margaret Rapp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne R. Reeves / Son 20466 Hickory Creek Ct. Leonardtown, MD 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 【XCremation 3 □ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) $oldsymbol{\mathbb{B}}$ rinsfield-Echols Cre $oldsymbol{\mathbb{A}}$ Charlotte Hall, MD. 22. Name and Address of Facility Brinsfield Funeral Home PA. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Rd. Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examiner The law requires that the death certificate be executed as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 R No 1 Tyes 2 🐼 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: ٩ 1 Yes 3 DOA 4 Mursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: Hospitel or Attending 1 Natural 5 Pending 2 🗌 No investigation after death Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 2 8-05 mes 0 30. Name and address of derson who completed cause of death (Item 23a) (Type, Print) 24035 Three Notch Road, Hollywood, MD 20636 J. Patrick/Jarboe, M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP

32. Registr

8 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepe 05 1 - For State Registra Certificate of Death Rea. No 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Aughonth 29. D2/005 Year 6:50 P **Physician** ROSENTHAL Belle /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Collingswood Nursing and Rehab. Ctr. Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country)
New York 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F 95 134-10-0516 **Director** 20. 1910 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State ontain: it tiem 27 is marked other than "natural", or liems 23a or 28a-f show injury expiler traumatic event, the Medical Evaruhistic and inclined at 8. Montgomery MD Derwood 1 Yes 2 No Director 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code with 20855 7232 Millcrest Terr. Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White etc. White permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iter main injuryate other traumatic event, the Medical Ever □Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify ě 3 Nidowed 4 Divorced Year or Dates: ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Complet Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sophie Hodes Samuel Hodes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7232 Millcrest Terr. 19a. Informant's Name/Relationship (Type, Print) Glenda Goldman - Daughter Derwood, MD 20855 20b. Place of Disposition (Name of cometery, crematory or other place Ahavath Achim Cem. 20a. Method of Disposition Date 20c. Location - City or Town, State place) Sept. 2, 2005 Syracuse, NY 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Other (Specify) ° 4 ☐ Donation 22. Name and Address of Facility Torchinsky Hebrew Funeral Home, Inc 21. Signature of Juneral Jervice Linense 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheimev's Demention Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): physician Box 68760 pe Physician/Medicai as the IE FEMALE nse (23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown ģ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 **X**No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2CXNo 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. e Funeral Director: After t Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of Aug. 30, 2005 D58962 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15020 Shady Grove Rd., #300, Rockville, MD 20850

Registrar DHMH 17 Rev 1/2001

State

Shashank Patel,

AUG 31

2005

31. Date filed (Month, Day, Year)

32 Registrar's Signature

ALL I

State of Maryland / Department of Health and Mental Hygier 200530337 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** WILBUR **SMITH** 30. /Medical <u>August</u> 2005 4:55 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13124 Worcester Highway Bishopville Worcester If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1₫M 2□F Director 89 213-10-2398 March 19, 1916 Maryland Usual Residence of Decedent filed withIn 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location ral', or items 23a or 28e-f show Examiner: just be notified at 10d. Inside City Limits 1 ☐ Yes 2 X No Worcester Maryland Bishopville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13124 Worcester Highway 21813 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ X Married Baltimore, Maryland 21215-0036 1 Yes 2€No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th <u>self-emploved</u> permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If item 27 is marked other any injury or other treum..... Salvage Business is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Smith Margaret Showell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Helen H. Smith/wife 13124 Worcester Highway - Bishopville, MD 21813 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location · City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State St. Paul UM Cemetery 09/03/2005 * 4 ☐ Donation 5 ☐ Other (Specify) Berlin, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD Jolley Memorial Chapel 23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ig physician and as the burial-transit consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□ Unknown 9 Unknown signed I Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 4 Unknown 1 Yes 2 No 3 Probably Completed certificate has b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy performed' 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospitel or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this s after death.

I Director: After this d in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funerel [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho To the Fune completely fi Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lilah <u>C. Gonzaleź</u>, 314 Franklin Ave., Suite 104 Berlin, Maryland 21811 M.D31. Date filed (Month, Day, Year) 2 2005 32. Projestrar's Signature State Registrar

Vital Records, P.O. Box 68760

		-	For State Registrar	State of Marylar	nd / Depa • <i>Ce</i>	artment of H <i>rtificate of l</i>	lealth and I Death	Mental Hyg	giene 005	5 30338
	Physici	an	1. Decedent's Name (First, Middle, La					2. Date of Dea Month	nth Day Y	3. Time of Death
	/Medic Examin	al	ORVILLE J. SCA 44/Facility Name (If not institution, give			4b. City, Town, or	Location of Death	09	61 03 4c. County of	
		·.	Keninsula Region	ral Medicas Co	nter	Sali	Shery		Wic	Trica
	Funeral Director		213-24-1910	Sex 7. Age (In yrs. 79	. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min,	8. Date of Birth Month, Day 09/08	25	. Birthplace (State or Foreign VA
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	r 28e-f show	ctor	VA Accoma	ck /	Atlanti	.c				1 ☐ Yes 2 🔯 No
	ath with th	al Director	10e. Street and Number 32516 Wisharts P	oint Rd.		10f. Zip Code 2330)3		10g. Citizen of Wha	at Country?
36	after de	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 12 Yes 2 No If Yes, Give Year or Dates: 39		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Si n, Mexican, Puerti Specify:	pecify Yes or No- o Rican, etc.)		American Indian, White, etc. Llack
21215-0036	c * 3	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wor)	king	16b. Kind of Busin	
d 21	be filed withi ta! Hygiene. d other then event, II e N	Cor	17. Father's Name (First, Middle, Last	()	Lab	orer	18. Mother's Nan	ne (First, Middle,	Seafoo Maiden Sumame)	d
ılan	be de state	To Be	Julian Scarborou					Allen	,	
Maryland	2 8 2		19a. Informant's Name/Relationship	•	1	ng Address (Street a				
	teal teal m 2		Linda Scarboroug 20a. Method of Disposition	20b.	Place of Dispo	16 Wishar		Date At	20c. Location - Cit	
imo	Pages nent of ant: If it ury or o		1 Surial 2 Cremetion 3 C	_Hemoval from State		matory or other place Bapt. Ceme	1	07/05	Atlant	ic, VA
Baltimore,	permit Pages 1 Department of H Importent: If ite any injury or ot		21. Signature of Funeral Service Lice	nsep RDM k.		2. Name and Addres		uneral (Co., Inc.	Accomac, VA
	Physician		22 P v 1. Enter he use se, or an all ock, or he intrallure. List only lmm diate Cause (rinal disease or condition	periodions if at or used the dear on cause or each line.			g, such as cardiac		rest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conser	quence of):	0F L	3 NG			2 405
Ш	ed sit	Examiner	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a conse	quence of):					
8760,	cate be executed physician and the burial-transit		that initiated events resulting in death) Last	Due to (or as a consec	quence of):					
9	phy:	fedical		d.						
P.O. Box	The law requires that the death certifi te has been signed by the attending I page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of	al death 3	□Ectopic pregnancy □ Other (specify)			23d. Date o Month	f delivery Day Year
	v requires fhat been signed b should be deta	by	Part II. Other significant conditions	contributing to death but not re	sulting in the u	inderlying cause give	en in Part I.			te to the cause of death?
of Vital Records,		Completed						24a. Was a autop: perfor 1 Yes	sy prio med? dea	e autopsy findings available r to completion of cause of th? Yes 2 \(\sum \text{No}\)
Vita	Attending Physicien: Th r death. ector: After this certificate by the funeral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 🛣 Inpatient 2] ER/Outpatier	othe Othe		th (Check only or		C(1)
Jou	g Physier this neral dir	-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				ence 6 Other (Specify)
Division	uttending death. ctor: After y the funer	catio	1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	in .		M 1 []	Yes 2 □ No			
Divi	itel or Ati rs after d el Direct led in by	Certifi	4 Homicide determined	building, etc. (Speci	ify)			City or Tow	n, State)	or Rural Route Number,
	To the Hospitel or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Certification;	(Check only 2 Medicel Exa	hysician: To the best of my kn miner: On the basis of examin and manner stated	owledge, deat ation and/or in	vestigation, in my or	pinion, death occu	rred at the time, d	ate and place, and	due to the cause(s)
	To the within 2 To the Complete	Σ	29b. Signature and title of certifier	Mean	1	29c. License	122		9d. Date signed (6	5
7	111		30. Name and address of person who EDWARD KLOPP	considered cause of death (Ite	m 23a) (Type,	Print)	5-	501150.	ay Na	21861
y \	Sta Regist		31. Date filed (Month, Day, Year) SEP 0 6 2	32. Registrar's Sign	ature	ackoll.	-/, b	PHUSEL	E7, 120	21801
	ricgist	a,	OLI UDA	- VIII	I B	DENGL!				

DHMH 17 Rev 1/2001

213-34-1918

Scarbowyl

State of Maryland / Department of Health and Mental Hygier 2005 30339 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 3:30 PM September 2,000 Diana Louise Shimminger /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🕱 F 54 Yrs. 21 Director 1951 219-52-2197 Maryland Usual Residence of Decedent should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. marked other than "natural", or Itema 23a or 28e-f ahow 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ir than "natural", or Itema 23a or 28e-f show the Medical Examinar must be nutified at Yos 2 No Hagerstown Maryland Washington Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 117 N. Mulberry St. 21740 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baker Dept. Store 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other treumatic event size. 18. Mother's Name (First, Middle, Maiden Surname) Cleveland Theodore Dobson Annabelle Naomi McCoy Dobson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 143 Orchard Ave. Martinsburg West Virginia 25401 Gloria J. Sell (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Mem. Park | Sept.8 05 Hagerstown Maryland 14 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Douglas A. Fiery Funeral Home ene 1331 Eastern Blvd. N. Hagerstown Maryland 21742 /23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Castono 6 month Meterkhie disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner Physicien; The law requires that the death certificate be executed use as the burial-transit that initiated events attending physicien and resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death signed by the at d be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s hes autopsy performed? certificate 1 ☐ Yes 2 ☐ No 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After or Attending 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel C Hospitei 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 041667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nedscal lamps throughoun MD SH-L Michael McCormack 11110 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State 2005 SEP Registrar

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar 30340 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)
Barbara Ellen Shores 2. Date of Death 3. Time of Death **Physician** September 935 1,2005 /Medical ^{4a. Fecility Name (If not institution, give street and number)}
University Specialty Hospital Examin<u>er</u> 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore City 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 217-42-7408 1□M 2XF 60 Director 2-6-1945 Easton, Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23s or 28s-f shov Exaction invalue netified at De. Sussex Seaford Completed by Funeral Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 6106 Woodland Ferry Road 19973 USA 12. Was Decedent Ever in U.S. Armed Forces2 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) marked other than College (1-4or 5+) Hygiene. Home 12 years Homemaker 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi Lawrence Thomas Gay, Sr. Mary Bowers 19a. Informant's Name/Relationship (Type, Print)
Arthur Leroy Shores, Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19973 6106 Woodland Ferry Rd., Seaford, De. Health Hem 27 other 20a. Method of Disposition
1 Burial 2 Cermation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Pages 1 nent of P ant: If ite 5 permit. Page Department of Important: If any injury or once. Capitol Crematory 9-3-2005 Dover, De. `4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee R. Carroll Hurley Funeral HomePC Unwil 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of Cyring, such a cardia of trespirate 1 Grant and 1 Grant and 2 Interval Between Onset and Decretations. mmediate Cause (Final **Physician** 5 talu CARCINITIA Mila disease or condition resulting in death) morette /Medical Due to (or as a consequence of): Examiner Cer Cur our Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death Month 5 Cther (specify) P.O. 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 163PIRATO RY FARLLUZE VENTILH TOR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown HYPER TENSION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? Yes 22 No 2□ No 1 Yes 1 Tyes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred s after dec. ral Director: After the fire 1 Natural 5 Pending 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) James P. DUD00 1346 Lynn w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tries P. Flynn UniVERSITY SPECIALT 611. SULTH MIS HUSPITHL CHARLES 21230 31. Date filed (Month Day, Year) 32. Resistrar's Signature State 0 6 2005 Registrar

aybora Others

State of Maryland / Department of Health and Mental Hygiery 30341 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav Year /Medical Roslynd R. Stewart 08 30 05 1540 Ρ 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges <u>Prince Georges Hospital</u> Cheverly If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 ☐ M 2 🖫 F Yrs. Director 64 18,1941 Long Island, N.Y 579-54-0228
Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Directo MD. Prince Georges Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or USA Funeral 4816 Leroy Gorham Drive
Marital Status

12. Was Decedent Ever in U.S.
Armed Forces? 20743 or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. within 72 hours after 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 Specify: Black 3 ☐Widowed 4 ☐ Divorced "naturat". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th. Management Analyst U.S. Government other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked othe any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roger Paden Evelyn Eato 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Latasha R. Stewart/Daughter 1793 V111age Green Drive Hyattsville, Mp. 20785. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln 09-03-05 Brentwood, MD. 22. Name and Address of Facility MArshall's Funeral Home 21. Signature of Funeral Service Licensee Marshall 4217 9th. St. N.W. Washington, D.C. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical consequence of): Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a por sequence of Examine burial-translt The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ate has been sign page 2 should be 3 Probably Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 28 No Division of Vital 1 ☐ Yes Physician: 25. Was case referred to medical expriner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: npatient P 1∕AYes 2 ☐ No 2 ER/Outpatient 3□ DOA ate f Injury (Month, Day Year) er of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 303 lar 30. Name and advess of person who completed cause of death (Item 23a) (Type, Print) James Catevenis, M.D. #1 HOspital Drive, Cheverly, MD. 20785 31. Date filed (Month, Day, Year) 82. Registrar's Signature State SEP 0 2 2005 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygie 2e 0 5 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** David L. Sizemore 2005 August 12:43 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring
If Under 1 Year If Under 24 Hrs. Holy Cross Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Apr. 6, 1922 9. Birthplace (State or Foreign South Carolina **Funeral** Days 1 □ XM 2 □ F Hours 250-20-8375 83 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or Items 23a or 28a-f show 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Wheaton 1 TYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4011 Randolph Road 20902 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Black. þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Government t of Health and Mental Hygie If itam 27 is marked othar or other traumatic avent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James M. Sizemore Bessie Braxton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerline M. Sizemore / Wife 1702 Tulip Ave., Forestville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department of Important: If any injury or * 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 9/8/2005 Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home luce 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Sepsis /Medical Due to (or as a consequence of): **Examiner** Carcinoma colon with metastases Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2X No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ dnknown Alzheimer's Disease Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? Ves 21 No 1 Yes 2 🗌 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Hnpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Diractor: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D14876 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Gupta, M.D. 3503 Perry St., Mt. Rainier, MD 20712 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

SEP 0 2 2005

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	Division		Decedent's Name (Firs			<u></u>				2. Date of	Death			3. Time of Death	-
	Physici /Medi		BERNADET		IING-FU	_S00	ONG			Augus	_	_	Year 005	3:55 A	A
	Examir	er	4a. Facility Name (If not in					4b. City, Town, o		Death	4	4c. County o	of Death		
			Casey Hous				Lce last birthday)	Rockvi If Under 1 Year		l Wes a man of		Mont			_
	Funeral Director		5_Social Security Number 109 - 38 - 0739		M 2137	70	Yrs.	Months Days		Hrs. 8. Date of (Month, May 2	D_{ay} Year 9 , 1	935	9. Birthpl Coun Chi	ace (State or Foreig try) na	n
	and		Usual Residence of Dece 10a. State 10b.	dent County		10c. Ci	ty, Town or Lo	cation					10	Od. Inside City Limits	_
	Mary -f she fied	to	Maryland 1	Montgom	erv	F	Bethesd	2						1⊠Yes 2□No	
	r 28a	Director	10e. Street and Number	.ioiregon	icry		Jechesu	10f. Zip Code			10g. C	Citizen of W	hat Coun	try?	
	th wit 23a o	al D	6812 Granb	y Stree	et			2081	7		Ţ	J.S.A.			
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, it a Madical Exertities must be natified at 200cs.	by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 D	i	12. Was Decedent I Armed Forces? 1 Yes 2 1 N If Yes, Give Year or Dates:		1	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 ☒ No	lispanic Origir an, Mexican, F Specify:	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race Black Specify:	, White, e	etc.	
20	72 ho	ted	15. D	ecedent's Edu y highest grad	cation		16a. Deced	lent's Usual Occup	ation	daddia a	16b.	Kind of Bus	iness/Ind	ustry	-
21215-0036	within jene.	Completed	Elementary/Secondary		College (1-4or 5	+)		kind of work done DO NOT use retired Sician	during most o	r working	In	iterna	1 Me	dicine	
b	e filed Il Hyg othar	Be C	17. Father's Name (First,	Middle, Last)			1119	Sician	18. Mother's	Name (First, Midd					_
Maryland	uld be Venta Venta Irkad Itic av	To B	Tse-Yuan	Soong					Su-C	hing Cha	ng				
lar	2 sho and I Is ma		19a. Informant's Name/Re				19b. Mailin	g Address (Street		or Rural Route Nun		or Town, S	tate, Zip	Code)	_
	and lealth m 27		Tao Kuang		sband				treet,	Bethesda	7				
JO.	iges 1 it of h if ital		20a. Method of Disposition 1 🔀 Burial 2 ☐ Crer	mation 3 🗆 F	lemoval from State		cemetery, cren	sition (Name of natory or other plac	· 1	Date	20c.	Location - C	ity or Tov	vn, State	
Baltimore,	it. Partmer ritant njury		* 4 □ Donation 5 □ C			√ Pa:		Memorial			Roc	ckvill	.e, M	aryland	
Ba	Dermii Depar Impor any ir once.	in 9	Na-	A.	P	the	H)	NES-RINA .800 New	LDI FU Hampsh	NERAL HON	Æ,] Silv	INC.	rino	, MD 2090	Z
60,	Physician	i Examiner	23a. Part1. Enter the disc shock, or head radius immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immedia cause (Disease or injury that initiated events resulting in death) Last	(cic consequences	Pancrea uence of): uence of):	tic Carc					i	Approximate Interval Between Onset and Death	_
P.O. Box 68760,	t the death cer by the attendin ached for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregn in the past 12 month 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	idill	d. 3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	2 Feta	death 3	Ectopic pregnancy Other (specify)				23d. Date of Month		y Day Year	
	uires tha signed Id be del	by	Part II. Other significent of	conditions cor	tributing to death bu	t not res	ulting in the un	derlying cause give	en in Part I.		tobacco Yes 2	1		cause of death?	
Records,	The law requir te has been si age 2 should l	Completed								24a. Wa aut per	s an opsy formed?	24b. We	ere autops or to com ath?	sy findings available pletion of cause of	
Vital	ysician: The is certificate hadirector, page	Be C	25. Was case referred to a examiner?	medical					26. Place of	Death Check only	2 🔯 N one)	0 1	Yes 2	INO	
of	ting Ph	P	1 Yes 2 No 27. Manner of Death 1 Natural 5	Pending investigation	ospital: 1 Inpatier 28a. Date of Injun (Month, Day)		ER/Outpatient 28b. Time of Injury	28c. Injury Work	at	ng Home 5 Res 28d. Describe				Hospice	
Division	To tha Hospital or Attend within 24 hours after death To tha Funaral Director: completely filled in by the	Certification:	3 Suicide 6 4 Homicide	Could not be determined	28e. Place of Injubulding, etc.	ry - At ho . <i>(Specif</i>)	ome, farm, stre	et, factory, office		28f. Location City or To	(Street a own, Stat	nd Number te)	or Rural I	Route Number,	
	To tha Hospital within 24 hours a To tha Funaral I completely filled	edical	29a. Certifier 1 💢 C (Check only one)	ertifying Phys edical Examir	sician: To the best of nar: On the basis of and manner stat	examina	wledge, death tion and/or inv	occurred at the time estigation, in my or	e, date and p pinion, death o	lace, and due to the	e cause(s e, date an	s) and mann id place, and	er as stat d due to t	ed. he cause(s)	
	To tha within 2 To tha complet	M	29b. Signature and tille of	certifier		^ ^		29c. License	number		29d. Da	ate signed (/	Month, Da	ay, Year)	_
			一大	-//-			5	D-35	635		Aug	ust 3	1, 20	005	
	1		30. Name and a dress of a Joseph Kap						d. Roci	kville. M	arv1	and 2	0855		
	Sta	e	31. Date filed (Month, Day	, Year)	32 registra		ture		_, 1.00		-				_
	Registra		SEP	0 2 20	05 10000	, 1	y. Dos	well.							

			for State RegistraMEND#20boenFF	State of Maryland /	Depa <i>Cei</i>	artment of Hertificate of L	ealth a D <i>eath</i>	nd Mental H	gien Reg. No		30344
	==		1. Decedent's Name (First, Middle, L					2. Date of D	eath Da	ay Year	3. Time of Death
	Physici /Medic		Leo Godfrey St					August	30,	2005	12:50 A ^M
	Examin		4a. Facility Name (If not institution, gr			4b. City, Town, or		Death		County of Dea	
-	Funeral		Shady Grove Adven 5. Social Security Number 6.	Sex 7. Age (In yrs. last.	birthday)	Rockville	If Under 2	4 Hrs. 8. Date of 8		ontgome	rthplace (State or Foreign
	Funeral Director		494-18-9337	11XM 2□F 84	Yrs.	Months Days	Hours	4 Hrs. 8. Date of 8 (Month, D	ау, Үөаг 9 , 1	920 Ok	lahoma
	pug *		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or La	cation					10d. Inside City Limits
	Maryla 1 sho	rot	Maryland Washing								1 ☐ Yes 2 🛣 No
	r 28a-	lrec	10e. Street and Number	1	F —— <i>)</i>	10f. Zip Code			10g. C	itizen of What C	country?
	23a c	alD	17234 Spielman R	.oad		21733			Uni	ted Sta	tes
36	should be filed within 72 hours after death with the Manyland and Mental Hygiene. marked other than "naturel", or Items 23a or 28a-f show imelic event, if a Manyleaf Existiliter is all be notified all imelic event.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marned 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 译Yes 2□No World If Yes, Give Year or Dates: War II	₫ '	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 2 No	spanic Orig n, Mexican, Specify:	in? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Am Black, Wh Specify:	
9500-6121	2 hou	ted	15. Decedent's i	Education 16		dent's Usual Occupa kind of work done do		of working	16b. F	Cind of Busines:	s/Industry
7	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired)		or working		nitatio	
7	iled w Hygier ther th		17. Father's Name (First, Middle, Las	-	IT	ıck Drive		's Name (First, Middl	1	partmen	.C
and	9 T 5 S	To Be	Godfrey Stehr	,				is Petty	o, maraor	, cumano,	
Maryland 2		-	19a. Informant's Name/Relationship	(Type, Print) 1	9b. Mailir	ng Address (Street a	nd Numbei	or Rural Route Num	ber, City	or Town, State,	Zip Code)
	1 and 2 Health a tem 27 le		Robert L. Stehr/				Court	Gaithers			
Baitimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3	□Removal from State	itery, crer	sition (Name of natory or other place) L Cemetery		eptember 6	1	ocation - City o. Worth,	
	permit. Pages Department of I Importent: If ite eny injury or o'		' 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service ico			•		2005 DeVol Fu	-		Texas
g	Dep Imp		* HAS	1111							g, MD 20877
			23a. Part . Enter the disease, or con shock of heart failure. List onl	mplications that caused the death. D							Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Respiratory	Fail	Lure					1 week
	/Medical Examiner		resulting in death)	Due to (or as a consequence Pneumonia	ce of):						1 week
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence	ce of):						1 week
	cuted nd ransit	Examiner	that initiated events	c							
Ď,	sate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequence	ce of):						
68/6U,	physic physic physic	dical		d							
XOR	death certificate be executed e attending physician and od for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy		75				23d. Date of de	elivery
ņ	death	slcia	in the past 12 months?	1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)				Month	Day Year
л. О	The law requires that the de ste has been signed by the a bage 2 should be detached	Phy	9 Unknown	contributing to death but not resulting	c in the w	nderlying cause give	o in Part I	23e Did	tohacco	use contribute t	to the cause of death?
Hecords,	uires that signed t Id be det	d by	Renal Failure		y		., .,				robably 4 \Unknown
S	w requir s been si should	Completed	Sepsis					24a. Wa		24b. Were a	utopsy findings available
Ä	The law cate has page 2	E O						per 1 Yes	opsy formed? 2 ₩ No	death?	completion of cause of s 2 No
Vital	Physicien: The this certificate al director, pages	Be C	25. Was case referred to medical examiner?					of Death (Check only			
0	Phys this al dii	2	1 ☐ Yes 2 🛣 No 27. Manner of Death		Outpatien	t 3 DOA Othe	4 🗆 Nul	sing Home 5 Res			ecify)
		tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Day Year)	Injury	Work	at ? ′es 2.⊟N		r now inju	ny occurred	
DIVISION	I or Attendi after death. Director: A d in by the fu	Certification:	3 Suicide 6 Could not determine	be one Bloom of Injury. At home	farm, str	eet, factory, office		28f. Location City or To			lural Route Number,
5	ital or irs aft rel Dir lled in										
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical		Physician: To the best of my knowled aminer: On the basis of examination and manner stated.		vestigation, in my op	inion, death		, date an	d place, and du	e to the cause(s)
		Σ	29b. Signature and title of certifier			29c. License				ate signed (Mon	
	15+1		E LAP	a completed games of J4- De CO	a) (T::::-	D6316	0		Aug	ust 30,	2005
				o completed cause of death (Item 23) M.D. 9901 MEdical			. Roc	kville M	arv1.	and 208	50
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signature	Son	sally	, 100	rice Pile		<u> </u>	2.0
	Regist	ar	SEP 01 2	2005 Brews D.	1						

DHMH 17 Rev 1/2001

			For State Registrar		State o	f Marylar		artment <i>rtificate</i>			ınd M	lental l	Hygie Req	200)5	30345
	Physicia		1. Decedent's Name (I		st) D JOSIE	SHEPPA	RD			-		2. Date of Month	f Death	Day	Year 2005	3. Time of Death 1:40 P ^M
	/Medic Examin		4a. Facility Name (If no	-		n <i>ber)</i>		4b. City, T		ocation o	f Death			4c. County		
	Funeral Director		5. Social Security Num 214-26-093		Sex I□M 2]X[]F	7. Age (In yrs. 72		If Under 1 Months		If Under 2 Hours	24 Hrs. Min.	8. Date o (Month Feb.	f Birth , Day, Y			place (State or Foreign
	show		Usual Residence of De 10a. State 10	ecedent 0b. County		10c. C	ity, Town or Lo	cation							1	0d. Inside City Limits
	ith the Ma or 28a-f s	Director	Maryland 10e. Street and Number		rford			10f. Zip (Code	e de	Grad	ce	10g	. Citizen of		1 Mary 2 No
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Experiment must be notified at	by Funeral	11. Marital Status 1 □ Never Married 3 🏿 Widowed 4 [2 Married		2 🔯 No ∕e		Was Deceder f Yes, speci			gin? (Spe , Puerto	ecify Yes o Rican, etc.	r No-		ce - Americ ck, White,	
21215-0036	within 72 hou iene. 'than "natura ith Medical E	Completed		5. Decedent's E only highest gra ary (0-12)	ducation		(Give	dent's Usual kind of work DO NOT use OUSEKE	done du retired)	iring most	of worki	ing		b. Kind of B		,
Maryland 2	iould be filed i Mental Hygis barked other batic event, L	To Be C	17. Father's Name (Fit Oliver F			ns	·				r's Name La Sr			iden Sumar		
	1 and 2 shou Health and M em 27 is mai		19a. Informant's Name Tara D.			ghter	-							ity or Town,		code) land 21078
Baltimore,	Page nent o ant: If ury or		20a. Method of Dispos 1 X Burial 2 0 4 Donation 5	Cremation 3		State	Place of Dispo cemetery, crer James	natory or oth	ner place,		9/6)ate /05		c. Location Havre		own, State
Balt	permit. Departr Importe any Inji		1 de	of Funeral Service Licensee 22. Name and Address of Facility Lisa Scott Fun 552 Lewis Stree her the disease, or complications that caused the death. Do not enter the mode of dying, such as car								. Hav	re d	e Grad	ce, M	D 21078
68760,	aath certificate be executed attending physicien and for use as the burial-transit	edicai Examiner	shock, or heart fi limmediate Cause (Fir disease or condition resulting in death) Sequentially list condi- fl any leading to Immer cause. Enter Underly Cause (Disease or injulat initiated events	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition											r Se	Approximate Interval Between Onset and Death
P.O. Box 6	Physicien: The law requires that the death certificate has been signed by the attending this certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent print the past 12 mo 1 ☐ Yes 2 ☑ N 9 ☐ Unknown	onths?		ointh 2 ☐ Feta ant at time of	al death 3	Ectopic pre Other (spe					u-17	1	nte of delive onth	Pry Day Year
Records, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significa	ant conditions		eath but not re	,		use giver	n in Part I.			I □ Yes	2 🗆 No	3 Prob	ne cause of death?
al Rec	ilcien: The law certificete has t rector, page 2 s	Completed			C	polsi hmié	obstr	nctive	-		V.:-	Severy		d?	prior to cor death?	psy findings available npletion of cause of
of Vital	ding Physicien: The h. h. After this certificete ha funeral director, page	To Be	25. Was case referred examiner? 1 X Yes 2 No		_		ER/Outpatier		Other	: 4□ Nui	rsing Hor		Residenc	e 6 □Oth)
Division o	To the Hospitel or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Certification;	2 Accident	ner of Death Natural 5 Pending Accident Injury Suicide 6 Could not be 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28b. Time of Injury M 28b. Time of Injury At home, farm, street, factory.								28f. Locatio				l Route Number,
	e Hospitt 24 hours Funeral	Medical C			nysician: To the miner: On the ba and man											
	To th withir To th	Me	29b. Signature and titl	g m	RZA,					311				Date signe	3/-0	
_	D		30. Name and address 6/5, 50 31. Date filed (Month,	s of person who	nien A	e of death (Ite	m 23a) (Type, lavre	Print)	622	ee)	/	UD;	, 2	-107	8	
	Sta Registr		31. Date filed (Month,	035 bm) 0	2 2005 ^{2. R}	ature #										

			1 - For State Registrar	State of N	Maryland	d / Depa	artment of I	Health a Death	nd Mental Hy	giene 0	05	30346
			Decedent's Name (First, Middle	a, Last)					2. Date of De	ath		3. Time of Death
	Physici		Hildegard	В.		Ste	wart		Month August	27 :	2005 ear	1330 M
	/Medio Examir		4a. Facility Name (If not institution	, give street and numbe	er)		4b. City, Town, o	or Location of			nty of Death	
	LAGIIII		Regency Assis	ted Livino	Facili	itv	Gambr	i 11 c			ne Aru	
	Funeral		5. Social Security Number	<u>~</u> _	Age (In yrs. Ia		If Under 1 Year	If Under 2		th		
	Director		503-05-2042	1 ☐ M 2 XX	85	Yrs.	Months Days	Hours	Min. (Month, Da	ay, Year) 19_192(place (State or Foreign intry) tth Dakota
	p .		Usual Residence of Decedent					-l	TIGI CII	17,1720	7 500	ch bakota
	irylar thow	_	10a. State 10b. County			, Town or Lo						10d. Inside City Limits
	Ba-1 s	cto	MD Anne	Arundel		Odento	n					1 ☐ Yes 2/CXNo
	ith th	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	intry?
	23e	ral	499 Saltoun A	Avenue			21	113		US	A	
	r deg	Funeral	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S	S. 13. \	Was Decedent of H	lispanic Origi an. Mexican.	in? (Specify Yes or No Puerto Rican, etc.))- 14. F	Race - Ameri Black, White,	ican Indian,
36	or in	by Fu	1 Never Married 2 Marri	If Yes, Give	_		1 ☐ Yes 2 🛣 No				cify: Wh:	
00	hours after death with the Maryland tural', or flems 23e or 28a-f show at Examinational be notified at	d b	3 XWidowed 4 ☐ Divorced	Year or Dates	s:					C C C C C C C C C C C C C C C C C C C	J., y	
1 5-	n 72 •nat	Completed	15. Decedent (Specify only highes			(Give	dent's Usual Occup kind of work done	during most of	of working	16b. Kind of	Business/In	ndustry
12	within ene.	dm	Elementary/Secondary (0-12)	College (1-4o	or 5+)	Telle	DO NOT use retire	a)		Pon	1-4	
2	be filed within 72 hours after death with the Marylar Ital Hygiene. Id other then "natural", or items 23e or 28e-f show event, the Midical Examber or ust be notified at		17. Father's Name (First, Middle,	Last)		тетте	. L	18 Mother	's Name (First, Middle		king	
Maryland 21215-0036	Mental Mental arkad o	To Be	Herman J. Blase	•					elia Pollac		amej	
ary	AS DE E	-	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailin	g Address (Street	and Number	or Rural Route Numb	er, City or Tow	m, State, Zi	o Code)
Ž	D ~ ~ =		Lynne Champagne	(Daughter)				, Odenton,			
ē,	s 1 a f Hea itam otha		20a. Method of Disposition	-	20b. Pla	ace of Dispo	sition (Name of natory or other plan	001	Date	20c. Locatio	n - City or T	own, State
E	Page ient c nt: # ry or	1	1 XXurial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (St				Vet. Cem		3-30-2005	Crown	sville	e MD
Baltimore,	permit. Pages 1 and Deportment of Healt Important: If itam 2 any niury or other once.	. 1	21. Signature of Funer Service I		IIGI				al Home, P.		PATTI	e, rii
m	Department of the contract of		· Oar 1	1/1		<u> </u>	lardesty 12 Ridge1	Funera V Aver	al Home, P. nue, Annapo	.A. olis. M	m 214	01
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus	ed the death.						214	Approximate
JI.	Pnysician	§	Immediate Cause (Final	Jilly One Cause on each	Y	. 1	- 12	100	Ca			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or a	as a conseque	ence of):	ve 1	Der	Coro			25 months
П	Examiner					B	Cont C	- Wac !				Iltrice
	THE SE	ner	Sequentially list conditions, I any, I am to introduce cause. Enter Underlying Cause (Disease or injury that initiated events	Die to (or a	is a consequ	ariea ut):	Melinal, S.					11713
	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events	c.								
Ó	e exe	EX	resulting in death) Last	Due to (or a	s a conseque	ence of):						
8760,	icate be executed physician and s the burial-transit	dical		d								
9	ndiffic ing pl	Med	IF FEMALE:	1							1	
Вох	leath certific attending p	an/	23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth	e of pregnan 2 Fetal o		Ectopic pregnancy	,			Date of delive	
0	ne dea the al	SCi	in the past 12 months? 1 Yes 2 D No	4☐ Pregnant 9☐ Unknown	at time of dea		Other (specify)			,	Month	Day Year
<u>a</u> .	that the di	Physician/Me	9 Unknown									
Ś	ires tha signed	by	Part II. Other significant conditio	ns contributing to death	but not resur	ting in the un	iderlying cause giv	en in Part I.		_		he cause of death?
orc	w requir been si should	ted							1_\	res 2□No	3 Prob	pably 4 Unknown
Records,	2 2 2	Completed							24a. Was		. Were auto	psy findings available mpletion of cause of
_		Cou								med?	death? 1 ☐ Yes	20 No
Vital	icien: Th certificate ector, pag	Be	25. Was case referred to medical examiner?						f Death (Check only o	ne)	050	11/5
	Physicien: this certific ral director,	은	1 ☐ Yes 25 No	Hospital: 1 ☐ Inpai		R/Outpatient		4 🗀 14013	ing Home 5 Resid		ther (Specify	1321-51 (1/3/2)
n O	ding F h, After funera	on:	27. Manner of Death Natural 5 ☐ Pending	28a. Date of In (Month, D	jury Jay Year)	28b. Time of Injury	28c. Injun Wor		28d. Describe h	now injury occi	urred	9
Sic	Attanding r death, ector: After by the funer	catl	2 Accident investig	not he				Yes 2 □ No				
Division of	or Al after of Direction by	Certification:	4 Homicide determi	nod 286. Place of II	njury - At hom etc. <i>(Specify)</i>	ne, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and Nun m, State)	nber or Rura	d Route Number,
_	To the Hospital or Attanding within 24 hours after death, To tha Funaral Director: After completely filled in by the funer		29a. Certifier Certifying	g Physician: To the bes	at of my know	dedan dant	occurred of the city	an details	alaaa as d d i iii			
	24 hc 24 hc 24 hc Fun etely	Medical	(Check only 2 Medical E	Examiner: On the basis and manners	of examination	on and/or inv	estigation, in my o	ne, date and p pinion, de <i>a</i> th	occurred at the time,	date and place	nanner as st , and due to	tated. the cause(s)
	of the of the omple	Me	29b. Signature and title of certifier		3 /		7 29c. License	e number		29d. Date sign	ed (Month,	Day, Year)
	->-0		1/ Km	_//////	10			1716		A a	200	9 2005
			30 Name and address of person v	who completed cause of	death (Item 2	23a) (Type. F	Print)	111)) /	July	51.7	1,200)
		(KUSSEN Q.O	Je Luca (16)	1-3	70	Hospi	Fed a	JEINP. G	17n B	Mary /	W-2106/
	Sta		31. Date filed (Month, Day, Year)	2. Regis	trar's Signatu	ire	Ü					, , ,
	Registr	ar	AUG 3 1 2	JUS /	K	hoe	All a					

30347 State of Maryland / Department of Health and Mental Hygie? [] 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Physician 29, AUGUST ELIZABETH SHORTER 2005 8:15A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES HOSPITAL CENTER CHEVERLY

If Under 1 Year | If Under 24 Hrs. PRINCE GEORGES 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M XX F Director 67 1938 SOUTH CAROLINA <u>579 52 2471</u> Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan neal of Health and Mental Hygiene.
and: If item 27 is marked other than "natural; or Items 23a or 28a-f show uny or other thaumatic event, the Medical Expriment must be availined at XXYes 2 No Directo MARYLAND PRINCE GEORGES CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6311 MARTIN LUTHER KING HIGHWAY 20743 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ∑∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 11THRADIOLOGY ESCORT PROVIDENCE HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 EUGENE PALSEY CARRIE WALKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, JACQUELINE SHORTER / DAUGHTER 833 CARRINGTON AVE. CAPITOL HEIGHTS, MD 20743 Important: If item any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State LINCOLN CEMETERY 9-3-2005 SUITLAND, MARYLAND ^ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 21. Signature of Funeral Service Licensee once 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Annroximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Hoche disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Hypertension Due to ras a consequence of: Sequentially list conditions, any, but in 1 immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

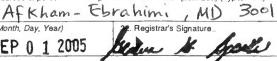
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 Yes To the Hispital or Attending Physician: 25. Was case referred to medical exampler? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a To the Funeral L 1 E/Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a Certifier Medic

State Registrar

29b. Signat

31. Date filed (Month, Day, Year) SEP 0 1 2005

and title of certifier



and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

3001

29d. Date signed (Month, Day, Year)

Cheverly

20737

Maryland

			1 - For Stata Ragistrar		State	of Mar	ryland	/ Depa	artment <i>rtificate</i>	of H	ealth D <i>eath</i>	and M	lental Hy	giene Rag. No	2005	303	348
			1. Decedent's Name (First, M	iddle, La	st)				-				2. Date of De	ath		3. Time	of Death
	Physicia /Medic		Carl	Euge	ne	Sic	kles						August	Da - 30	•	5:30) A ^M
	Examin	er	4a. Facility Name (If not instit				Cen	ter	4b. City, T						. County of Dea		
			Shady Grove 5. Social Security Number	Adv			sing (In yrs. las	t hirthday)	If Under 1		kvi	lle or 24 Hrs.	S Data of Bi	45	Montg		
	Funeral Director		301-12-2680		™ M 2□F	_ :	80	Yrs.		Days	Hours		8. Date of Bi (Month, Da Feb. 2	ay, Year)	C	thplace (State ountry)	or Foreign
	D		Usual Residence of Deceden						1				reb. z	. 1 و 0 .	723 0	1110	
	show	_	10a. State 10b. Co	•		1	10c. City, ⁻	Town or Lo	ocation							10d. Inside (City Limits s 2 □ No
	the M	ecto	MD MOT	tgon	ery			Gait	hersb					10. 0			
	with sa or	2	28 Brighton D	rive					10f. Zip (208	277			iog. Ci	tizen of What C		
	death ms 2;	Funeral Director	11, Marital Status		12. Was Dec		ver in U.S.		Was Decede	ent of Hi	spanic O	rigin? (Spe	cify Yes or No)-	United 14. Race - Am	erican Indian,	
9	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ont, I'm Medical Exam or must be confilled at	Fu	1 ☐ Never Married 2 🛣		Armed F	2 TNo)		If Yes, specif 1 ☐ Yes 2		n, Mexica Specify		Rican, etc.)		Black, Whi	te, etc.	
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פ	0 - 0 2	BeC	17. Father's Name (First, Mid)								(First, Middle		Sumame)		
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	1 and Health em 2 ther 1		20a. Method of Disposition		S) WII		20b. Plac	e of Dispo	sition (Name	e of			e #2819		llver Sp	oring	
пÖ	ages ant of tr: If it		1 ☐ Burial 2 🛣 Cremat 4 ☐ Donation 5 ☐ Othe			n State	Metr	netery, crer ODOLI	natory or oth .tan	er place	9)		st 30,				
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.	1	21. Signature of Funeral Sen				U	remat 22	OLy 2. Name and	Addres	s of Faci				xandria al Home		
ñ	P P F P P		TRACY A.	Str	w			De	er Par	rk D	rive	, Gai	thersb	urg,	MD 208	377	ast
			23a. Part1. Enter the disease shock, or heart failure.	, or com List only	plications that one cause on	caused the	he death.	Do not ent	er the mode	of dying	g, such a	s cardiac o	r respiratory a	rrest,		Approxima Interval Be	ate etween
	Physician		Immediate Cause (Final disease or condition		а	E	End S	tage	Dement	tia						Onset and	I Death
	/Medical Examiner		resulting in death)		Due to		conseque										
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	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<			,	,									
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9			IF FEMALE:	\neg I	22a If year as									П			
Box	death certific e attending p d for use as i	Physician/M	23b. Was decedent pregnan in the past 12 months?	Ī		birth 2	r pregnanc Fetal de me of deal	ath 3	Ectopic pre						23d. Date of de Month	,	Year
o	0 0	nysk	1 □ Yes 2 □ No 9 □ Unknown		9□ Unki		ino or dear	J_		City)							
<u> </u>	law requires that the as been signed by th 2 should be detache	by Pł	Part II. Other significant con	ditions	ontributing to	death but	not resulti	ng in the u	nderlying ca	use give	n in Part	1.	23e. Did 1	obacco	use contribute to	o the cause of	death?
rds	w requires that been signed b should be deta										_		1 🗆	Yes 2	□No 3□P	robably 4 🛚	Unknown
ecords,	law re as be	Completed											24a. Was		24b. Were a	utopsy findings completion of	available
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Vital	certificate	Be	25. Was case referred to me examiner?	dical	Hospital					0.1		e of Death	(Check only	one)			
o	Physic this cral dir	. To	1 Yes 2XNo		Hospital: 1			VOutpatier			4 (2)		ne 5 Resi 28d. Describe		6 Other (Spe	icity)	
O	th. : After funer	tlon	1 XNatural 5 □ Pe	nding estigation	(Mo	nth, Day	Year)	Injury	M	c. Injury Work	.? ′es 2.⊑		.bu. Describe	riow irijui	ry occurred		
Division of	or Attending Physician: uffer death. Director: After this certific in by the funeral director.	ifica	3 Suicide 6 □Co	uld not b	e 28e. Plac	e of Injury	y - At hom	e, farm, str	eet, factory,						d Number or R	ural Route Nur	nber,
	tal or	Certification:	4 🗀 Homicide		Build	ding, etc.	(Бреспу)						City or To	wn, State	9)		
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu		(Check only 2 Med	fying Ph	niner: On the :	dasis of e	examination	edge, deati	h occurred at	t the tim	e, date a	ind place, a	and due to the	cause(s)	and manner as	s stated.	9)
	thin 2: the f the f mplete	Medical	one) 29b. Signature and title of ce		and ma	nner state	ed.				number		3 2 (11116,		te signed (Mont		
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	5+1		30. Name and address of per		completed car	use of dea	ath (Item 2	3a) (Type									
			Usha Gullapa							ock	v111	e. Mo	20850				
	Sta	. T. A.	31. Date filed (Month, Day, Y	ear)	\$2.	Registrar'	's Signatur	Special Specia	d.	46.400(25)					-		
	Registr	ar	AUG 31	200) March	w.	J. J	15 TO A									

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiepe 1 - For State Registrar 30349 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month Day **Physician** AUGUST 30, 10:35 A.M SLAVIN 2005 JULIET /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROCKVILLE MONTGOMERY CASEY HOUSE 8. Date of Birth (Month, Day, Year) JAN 5, 1931 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5 Social Security Number 6. Sex **Funeral** WASHINGTON, DC Months 1 □ M 2 🖾 F 74 Director 579-38-3425 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits or other treumetic event, the Modical Examiner must be notified at 10a State 10h County 1 Tyes 2 □ No MARYLAND MONTGOMERY CHEVY CHASE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4620 N. PARK AVENUE, #908E 20815 UNITED STATES death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Importent: If tiem 27 is marked other then "neturel" or the gone. 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be MARKWOOD SHIRLEY MANDELL LOUIS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4620 N. PARK AVENUE, #908E CHEVY CHASE, MD 20815 LEON J. SLAVIN, HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Buriat 2 ☐ Gremation moval from State GARDEN OF REMEMBRANCE CEM. SEPT 2, 2005 CLARKSBURG, MARYLAND 4 □ Denation 5/□ Other (Specify 21. Sign ture of Fun pal Service L EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, shock, or heart failure. L e, d Lis Immediate Cause (Final disease or condition resulting in death) METASTATIC COLON CANCER **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physician at s the burial-t Division of Vital Records, P.O. Box 68760. Physician/Medical attending IF FEMALE 1Se 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Year in the past 12 months? ò 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRONIC LYMPHOCYTIC LEUKEMIA 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performed page 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2X No Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 🏋 No 2 ER/Outpatient 3 DOA 5 Residence 6 X Other (SHOSPICE 2 this After thi Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical werrung rnystrems. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manners taked. (Check only one) Within 2 the 29d. Date sig ned (Month, Day, Year) 29c. License number 29b. Signature and 2 pleted cause of death (Item 23a) (Type, Print) ROCKVILLE, MD 20855 6001 MUNCASTER MILL ROAD, CHARLES HARRISON, M.D., 3 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 31 2005 Registrar

			1- State Registrar	of Maryland /	Depa	artment of He rtificate of D	ealth and Me			3035	0
			Hegistrar 1. Decedent's Name (First, Middle, Last)		061	tincate of L		2. Date of Deat		3. Time of Dear	th
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	Examir		4a. Facility Name (If not institution, give street and			4b. City, Town, or I			4c. County of		
			ST. VINCENT de PAUL N 5. Social Security Number 6. Sex	URSING CENT 7. Age (In yrs. last		FROSTBUR		5 D-1 - 4 B'-t-	ALLEGA		
	Funeral Director		1 ⊠ M 2□1		Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 31-Jul-1	Year) 9.	Birthplace (State or For Country)	eign
	P.		217-18-4353 Usual Residence of Decedent					J1-JUI-1	725		
	arylar show	<u>_</u>	10a. State 10b. County	10c. City, To						10d. Inside City Lin 1	
	the M	ecto	Maryland Allegany 10e. Street and Number	Corriga	anville	10f. Zip Code			3- 03:		INO
	3a or	I Dii	12821 Ellerslie R	oad		21524-		1	og. Citizen of Wha J.S.A.	at Country?	
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-1 show ha Medical Examinar must be notified at	by Funeral Director	11. Marital Status 12. Was D	ecedent Ever in U.S. Forces?	13.	Was Decedent of His f Yes, specify Cuban	panic Origin? (Spec		14. Race -	American Indian,	
36	or Its	y Fu	1 Never Married 2 Married 1 Yes.	S 2 No Give		1 □ Yes 2 🕱 No	Specify:	ioan, etc.)		White, etc.	
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215	hin 72 9. Sin "ne Medii	plet	(Specify only highest grade complete	e (1-4or 5+)	(Give life. l	kind of work done du DO NOT use retired)	iring most of working	g	TOD. TAILE OF BUSIN	ess industry	
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and	ntal H ed ott	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		faiden Surname)		
Maryland	2 should be filed withir and Mental Hygiene. Is marked othar than aumatic evant, the Ms	2	Tonas Skidmore 19a: Informant's Name/Relationship (Type, Print)	1	9b. Mailir	ng Address (Street ar	Thelma Day		City or Town. Sta	te Zin Code)	
	alth a		Hilda Skidmore si	oouse	12821	Ellerslie Road	l Corri	nganville	Maryla	nd 21524	
ore	of He If itan		20a. Method of Disposition 1. ■ Burial 2 □ Cremation 3 □ Removal from		of Dispo	sition (Name of natory or other place			0c. Location - Cit		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any hojury or other traumatic event, the Medical Examinating to public a any hojury or other traumatic event, the Medical Examinating the modified at Once.		' 4 □Donation 5 □ Other (Specify)		-	Iemorial Park		ug-2005 F	rostburg	Maryland	
Bal	permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any Injury or othar trae		21. Signature of Funeral Service Licensee	ret		. Name and Address urst Funeral		rost Ave.,	Frostburg,	MD 21532	
ı			23a. Part. Enter the disease, or complications the	at caused the death. D	o not ent	er the mode of dying,	such as cardiac or	respiratory arre	st,	Approximate Interval Between	
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68760,	tificate be executed g physician and as the burial-transit	ai E)	Due	to (or as a consequent	ce of):						
687	ificate g phys as the	edicai	d								
Вох	eath cert attending for use a	an/M	23b. Was decedent pregnant	outcome of pregnancy e birth 2 Fetal dea	ath 3□	Ectopic pregnancy			23d. Date of	delivery	
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	1 Voc 2 No	egnant at time of death		Other (specify)			Month	Day Year	
P.0	uires that the de signed by the a Id be detached f		Part II. Other significant conditions contributing t	o death but not resulting	g in the ur	nderlying cause giver	in Part I.	23e. Did tob	acco use contribu	te to the cause of death?	?
Records,	quires n sign uld be	ed by	URINARY BLADI	BROWT	ET	OBSTRE		1 ☐ Ye	s 2□No 3□	Probably 4 Gunkno	wn
000	law requir as been si 2 should	Completed	PROSTATE	EN CARO	15 N	VENT		24a. Was an	24b. Wer	e autopsy findings availa	able
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Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? Hospital:				26. Place of Death				
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on	nding th. : After	ıtlon		lonth, Day Year)	Injury	Work?	es 2 □No	d. Describe not	winjury occurred		
Division of Vital	er dea ractor	Certification;	3 ☐ Suicide 6 ☐ Could not be	ace of Injury - At home, ilding, etc. (Specify)	farm, stre	eet, factory, office	28	If. Location (Str. City or Town,	et and Number o	r Rural Route Number,	
	ital ours aft ral Di						1				1)
	To tha Hospital or Attanding Phwithin 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) Certifying Physicien: To 2 Medicel Exeminer: On the and m	the best of my knowled b basis of examination anner stated.	lge, death and/or inv	occurred at the time restigation, in my opin	, date and place, an nion, death occurred	d due to the car I at the time, da	use(s) and manne te and place, and	r as stated. due to the cause(s)	
	To the To the comp	×	29b. Signature and title of certifier	.1		29c. License		29	d. Date signed (M	fonth, Day, Year)	
•	2		> House			126	707	A	vaist	29, 2005	
	¢,00		30. Name and address of person who completed of Harjit Sidhu, 1	n.A. 925	а) (Туре, В ,	shop Wa	Ish Rd,	Cum	berland	29, 2005 P, MID 215	02
	Sta Registr			. Registrar's Signature	1.	1	7				
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DHMH 17 Rev 1/2001

			1 - State Amend Item	State of Ma 26 per ver	ryland / Dep b.,G855_©0	artment of H	lealth and I Beath	Mental Hyg	piene 2005	30351			
			1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea Month		3. Time of Death			
	Physici /Medic		AnnaS.	Tate				08	30 0	5 9:20 P M			
	Examin		4a. Facility Name (If not institution, give				Location of Deatl	h	4c. County of				
		•	Holy Cross Hos		//		Spring If Under 24 Hrs.	Dob -4 Dist	Montg				
	Funeral Director		0/2-34-5882	ox 2 x 7. Age 7	(In yrs. last birthday, Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 05-23-3		9. Birthplace (State or Foreign Country) Virginia			
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits			
	Maryl 4 sho	jo	MD. MOntgor	nerv	Silver	Spring				1 ☐ Yes 2 ☐ No			
	28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Country?			
	h with	a D	1316 Fenwick Lane	5		20901			USA				
	deat ams	Funeral	11. Marital Status	12. Was Decedent B Armed Forces?	Ever in U.S. 13.	Was Decedent of H	ispanic Origin? (S	pecify Yes or No-	14. Race	- American Indian, White, etc.			
0000-01717	S. Faring 2 should be the writing to house area destinant the wearen transfer and Montal Hygiene. It am a faring Hygiene. It am a faring the area of show the traumatic awant, the Medical Examinational te collination.	by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 □ Yes 2 ☑ N If Yes, Give Year or Dates:	lo	1 ☐ Yes 2 ဩXNo		,		Black			
	iled within 72 hours after death with the Maryland Hygiene. the than "natural", or Itams 23e or 28e-f show the the Medical Exan and must be notified at	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occup	ation during most of wor	rking	16b. Kind of Bus	iness/Industry			
Ž	ithin 18n	nple	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	DO NOT use retired	<i>t</i>)						
7	led w lygier her th		47 Esthada Nama (First Middle) oot	2 yrs.	Ta	x Consult		no /First Middle	Self Employed				
	12 should be tiled within " h and Mental Hygiene. I is markad other than " raumatic avant, the Med	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden S										
Ž	d Mel d Mel mark	To	John L. Seaborn Bertha Broadnax 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,										
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ย์	of Health of Health Itam 27 i		20a. Method of Disposition		20b. Place of Disp	osition (Name of		Date		lity or Town, State			
aitimore,	0 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specif			matory or other place itan Cren		0_8_05	levandri	ia VA			
	그 두 만 구		21. Signature of Funeral Service Licer		Mecropol	2. Name and Addre	ss of FacilityMar	shall's	Funeral	Home			
ñ	Deparenti Impo		1 P March	all.		217 9th.							
			23a. Part Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Consett and Dr. Onsett and Dr. Onsett and Dr.										
	Pnysician		Immediate Cause (Final disease or condition Myocardial Infarction										
	/Medical		resulting in death) Due to (or as a consequence of):										
	Examiner	L	Sequentially list conditions, if any, leading to immediate b. Liabetes Due to (or as a consequence of):										
	sit sit	iner	dany, leading to immediate Due to (or as a consequence or): cause. Enter Underlying cause (Disease or injury										
_	and Il-tran	Examin	that initiated events resulting in death) Last	c. Hyperl Due to (or as	ipemia a consequence of):				<u>.</u>				
8/60,	cate be executed oblysician and the burial-transit	cal E		d. Hypert	ension								
٥	ificate g phys as the	edic	-										
. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Mont	of delivery h Day Year			
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	signed by det	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to							Probably 4 Unknown			
0	w requir been si should	eted	Peripheral A	rterial Di	sease			=====		_ , A-			
Records ,	has the	Completed	Asthma					24a. Was a autop	sv pri	ere autopsy findings available for to completion of cause of eath?			
						*		1 ☐ Yes	2x № 1]Yes 2□No			
Vital	Physician: this certitics ral director,	Be c	25. Was case referred to medical examiner?	Hospital:	-1 -2 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5	Oth		ath (Check only of		(0			
o	Phys r this ral di	To :	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date of Inju	ry 28b. Time	of 28c, Injur	v at	lome 5 🗆 Resid	ow injury occurred				
o	ding th. : Afte	tlor	1 Accident 5 Pending 2 Accident investigatio	(<i>Month, D</i> ay	Year) Injury	Wor	k? Yes 2 □ No						
Division	Attanding r death. Bctor: After by the tune	Certification;	3 ☐ Suicide 6 ☐ Could not b		ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (S	treet and Number	or Rural Route Number,			
S	al or	erti	4 Homicide	building, etc	с. (Эреспу)			City or Tow	n, State)				
	To the Hospital or Attanding F within 24 hours after death. To tha Funeral Director: After completely tilled in by the tuner	edical C		nysician: To the best on niner: On the basis of and manner sta	examination and/or is								
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed	(Month, Day, Year)			
)			Mulmsha	L MO		D517	24		8-31-0	5			
0	(m)		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	, Print)			*10.04				
1-			Dr. Neelam B.	Shah M.D	. 1500 F	orest Gle	n Rd. Si	lver Spr	ing, Md.	20910			
		ate	31. Date filed (Month, Day, Year)		ar's Signature								
	Regist	rar	SEP 0 2 200	Elden	A Appl								
DH	MH 17 Rev 1/2	2001		•	•								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 2e 0 5 30352 1-State
Registrar AMEND ITEM #5 PERFH G847 9/ Pertificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 2005 3:00 PM Thelma Q. Thomas 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring Holy Cross Hospital Montgomery 8. Date of Birth (Month, Day, Year) Apr. 17, 1923 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Months Days Hours Min 1 □ M 2 👽 F 82 Yrs. Wash., DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Maryland | Prince George's Largo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10200 Prince Place, #108 20774-1209 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. African 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Housewife Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Robert Queen Louise Bell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20774 10200 Prince Place, #108, Largo, MD Robert L. Thomas - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Tremation 3 Removal from State Chesapeake Crematory 9/2/2005 Beltsville, MD ^ 4 □ Donation 5 □ Other (Specify) Stewart Funeral Home 21. Signature of Puneral Service Licensee 22. Name and Address of Facility 4001 Benning Rd., N.E. Wash., DC 20019 ewa! 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or condition resulting in death) Due to (or as neur Due ty(or as a consequence of): Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Year Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical **Examiner**

permit. Pages 1
Department of H
Importent: If ites

Physician

/Medical

Examiner

10a. State

Funeral

Director

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or Items 23a

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Baltimore, Maryland 21215-0036

Director

Funeral

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Physiclan/Medical Completed Be 2

Examiner burial-transit Certification:

Division of Vital Records, P.O. Box 68760 e Hospital or Attending Physicien: 24 hours after death. e Funerel Director: After this certifice

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C/L			۷	/ 31:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 🗆 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number

-USSIE 31. Date filed (Month, Day, Year) Registrar's Signature-SEP 0 2 2005

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Registrar

ompleted cause of death (Item 23a) (Type, Print)

			For State Registrar 1. Decedent's Name (First, Middle, Last)		artment of H	Death	Reg. I	3. Time of Death
	Physicia			LOR				R 4, 2005 1355 M
	/Medic Examin	0	4a. Facility Name (If not institution, give str		4b. City, Town, or	Location of Death		4c. County of Death
			6555 DIAMOND HALL F	CAO	EASTO	N		TALBOT
	Funeral Director		5. Social Security Number 6. Sex 1 Number 1 Numb	7. Age (In yrs. last birthday) 7. Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea OCT. 21,	ar) 9. Birthplace (State or Foreign Country) 1925 MARYLAND
	land		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Mary -f sh	to	MD. TALBOT	EASTON				1 Tes 2 No
	r 28a	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Country?
	23a o	alD	6555 DIAMOND HALL F	CAO	21601			U.S.A.
	ems ems	Funeral	11. Marital Status	Armed Forces?	Was Decedent of H	ispanic Origin? (Specin, Mexican, Puerto R	cify Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc.
36	or It	by Fu	1 Never Married 2 Married		1 ☐ Yes 2 X No	Specify:		Specify: WHITE
Ö	within 72 hours after death with the Maryland ene. than "netural", or Hems 23a or 28a-f show fre Modical Exeminat the mullifud at the Modical Exeminat	q pe	3 Widowed 4 Divorced 15. Decedent's Educa	Year or Dates:	dent's Usual Occup	ation	16h	. Kind of Business/Industry
215-0036	in 72 n° r	olet	(Specify only highest grade of	ompleted) (Give	kind of work done of DO NOT use retired	during most of workin	g	. Title of Destrictor industry
212	yiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 2 Ho	OMEMAKER		0	WN HOME
פָ	at Hyg	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Maid	den Surname)
<u>Ja</u>	Menta Menta arked	2	CARL NEVIUS			JULIA F	ROSE MOR	GAN
, Maryland	and 2 sho alth and 127 is mu er trauma		19a. Informant's Name/Relationship (Type JEFFERY N. TAYLOR/		ng Address (Street a			ty or Town, State, Zip Code) PA. 19350
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy njury or other traumatic event, the Modical Examiner must be nullified at 91.		20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer 1 ☐ Donation 5 ☐ Other (Specify)		osition (Name of matory or other plac CEMETERY			Location - City or Town, State FORD, MARYLAND
Balti	permit. Deportu Imports any nju		21. Signature of Funeral Service Licensee	Example C.P.SP F		ELFENBEIN		FUNERAL HOME P.A.
1	Physician /Medical Examiner		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	tions that caused the death. Do not en cause on each line. Due to (or as a consequence of):	,			Approximate Interval Between Onset and Deap Constant Deap
0,	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):				
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.O. Box	that the death certifice hed by the attending phy detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)			23d. Date of delivery Month Day Year
σ	9 JG	by	Part II. Other significant conditions control	buting to death but not resulting in the u	inderlying cause give	en in Part I.	23e. Did tobaco	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
ecords	w requir been si should	Completed					24a. Was an	24b. Were autopsy findings available
α	he ha	шс					autopsy	? prior to completion of cause of death?
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<u> </u>	99	0 8	eyaminer?	spital: 1 Inpatient 2 ER/Outpatie	nt 3 DOA Oth	0.00		6 Other (Specify)
on of	ding h. After fune	ıtlon; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Wor	yat 2. k? Yes 2 □No	8d. Describe how in	njury occurred
Division	or A or A or A or A or A or A	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	2	8f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical C		rian: To the best of my knowledge, deal r: On the basis of examination and/or in and manner stated.				
	To the within 2 To the comple	Me	29b. Signature and title of certifier	W.	29c. Licens	e number 7	7 29d.	Date signed (Month Day, Year)
	15)		30. Name and address of person who com DAVID SMITH M.D.	pleted cause of death (Item 23a) (Type, 29466, PINTAIL DRI		N, MD 2160	01	
Y	Sta	ite	31. Date filed (Month, Pay Year) SEP 0.6 200	32. giştrar's Signaturu'n				

For State Registrar		, ,		rtificate			Mental	Reg. N	GUUN	30354
Decedent's Name (First, Middle, L	.ast)						2. Date of		ay Yea	3. Time of Death
Harold	Allen_	Tl	nirles				Sep	t. 1,	2005	6:45 a
. Facility Name (If not institution, g		nber)				ocation of De	ath	1	lc. County of De	
12906 10th Stre		7. Age (In yrs	laat histoslar	Bow If Under		f Under 24 H	rs. 8. Date o			George's
Social Security Number 6. 717-07-5860 sual Residence of Decedent	.Sex 11XΩM 2□F	99	Yrs.	Months		Hours M		, Day, Yea	1906 Bo	irthplace (State or Fore Country) Wie, MD
a. State 10b. County		10c. C	ity, Town or L	ocation						10d. Inside City Lim
aryland Prince	George's	5	Bowie							1¥X Yes 2 ☐ i
e. Street and Number				10f. Zip	Code			10g. (Citizen of What (Country?
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3 ⊠Widowed 4 □ Divorced	Year or Da					,		1	, , ,	
15. Decedent's (Specify only highest of	Education grade completed)		(Giv	edent's Usua e kind of wor DO NOT us	rk done duri	on ing most of v	vorking	16b.	Kind of Busines	ss/Industry
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. Father's Name (First, Middle, La	st)			Conda		B. Mother's N	lame (First, Mi			niza nazirot
William Henry T	hirles				Ì	Dais	y Smit	h		
9a. Informant's Name/Relationship	(Type, Print)	-	19b. Mai	ling Address	(Street and	d Number or	Rural Route N	ımber, City	or Town, State	, Zip Code)
Mazel A. Burns -	Daughte	r	1290	06 10t	h Str	eet, l	Bowie,	MD 2	0720	
a. Method of Disposition		1	Place of Disp	osition (Name	ne of ther place)		Date	20c.	Location - City of	or Town, State
a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 4 □ Donation 5 □ Other (Spe	☐Removal from S	State	Place of Disp cemetery, cre ropolit	ematory or ot	ther place)	9/	Date 2/05			or Town, State a, Virginia
1 ☐ Burial 2 To Cremation 3	Removal from S	State	cometery, cre tropolit	ematory or ot an Cren 22. Name and	natory d Address o	of Facility (2/05 Gasch's	Ale Fune	exandria ral Hom	e, Virginia
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Physician /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Importent: If Item 27 is marked other than "neturel", or Items 23e or 28a-f show any injury or other treumatic event, Its Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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4a. Was an autopsy performed? Yes 2X No	24b. Were au prior to death?

								1
Was case referred to medical					26. Place o	of Death (C	heck only one)	
examiner? 1 ☐ Yes 2 🔀 No	Hospita	i: 1 🗆 Inpatient	2 ER/Outpatient	3□ DOA	Other: 4 Nurs	sing Home	5X Residence	6 ☐Other (Specify)
Manner of Death	28a	. Date of Injury (Month, Day Yea	28b. Time of Injury	28c.	Injury at Work?	28d	. Describe how inj	ury occurred

Manner of Death	5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Inju Wo
2 Accident	investigation			М	1 [
3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stree	et, fact	ory, office

LJa	(Chec	k only		Examine	
			-	 	

29c. License number 027837

Ave. Takoma ParkMd. 20912

State Registrar 31. Date filed (Month, Day, Year) SEP 0 2 2005



10

State of Maryland / Department of Health and Mental Hygieze 0 30355 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 30, Marvin Wade Thompson August 2005 9:14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Georges Southern Maryland Hospital Clinton tf Under 1 Year | If Under 24 Hrs. 5. Sociat Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1**∑** M 2□ F Days Min. Hours Yrs. Director 229-64-0536 Virginia Mav Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other then "natural", or Items 23s or 28e-f show other traumatic event, the Mcdical Examinar must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Prince Georges Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? T-4 USA 1900 County Road 20747 Apt. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify:White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other then "n any injury or other traumatic event, the Med ance. Moving & Storage Elementary/Secondary (0-12) College (1-4or 5+) 6 Mover 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Archie Thompson Bertha Lewis ္ရ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Singer / Representative 1900 County Rd., T-4, Forestville, MD 20747 Jennifer 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State 9/1/2005 ^ 4 □ Donation 5 □ Other (Specify) Kalas Crematory Edgewater, MD 22. Name and Address of Facility George P. Kalas Funeral Home, 6160 Oxon Hill Rd.,Oxon Hill, Funeral Service Licenses 23a. Party Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cermatin FAIme disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Due to (or as a consequence of): DISEO SE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Artery Examiner the attending physician and hed for use as the burial-transit Sunntemat = Due to (or as a consequence of) BRAGYCANO) A P.O. Box 68760. death certificate be Physician/Medical Thiro Degras Bbac IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 Other (specify) þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 ho To the Func 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of bertifier 29c. License number DOO 4158 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kelso, Scott, M.D. Southern Maryland Hospital Tenter, 7503 Surratts Road, Clinton MD 🔐. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 0 2 2005

				artment of Health and Mental Hy	/giene 005 30356
П	• Physici	an	Decedent's Name (First, Middle, Last) TOCHELL WILL TO	TAYLOR 2. Date of D. Month S	Day Year
,	/Medic	al	JOSEPH WILLIS 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Examin	ler	CARROLL HOSPITAL CENTER	WESTMINSTER	CARROLL
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. 8. Date of Bi Months Days Hours Min. (Month, D.	rth 9. Birthplace (State or Foreign Country)
	Director		220-24-8967 1.6.1 M 2 F 75 Yrs. Usual Residence of Decedent	Months Days Hours Min. (Month, D 4/11/	1930 MARYLAND
	yland now		10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	e Mar 3e-f sl	Director	MD CARROLL FINKSB	JRG	1 ☐ Yes 2 ∑ No
	ath with the Marylan 23c or 28e-f show	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	ns 234	Funeral	7 E.MARYS CT. 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or N.	USA 14. Race - American Indian.
36	72 hours after death with the Maryland "neturel", or Items 23s or 28e-f show offsel Examitter mast be multibut at	by Fun	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or N- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X No Specify:	Black, White, etc. Specify: WHITE
20	"neturel",	eted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv.	edent's Usual Occupation a kind of work done during most of working	16b. Kind of Business/Industry
12	-	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	CONCEDUCETON
d 2	e filed v Il Hygie other t	e Co	9 17. Father's Name (First, Middle, Last)	PAINTER 18. Mother's Name (First, Middle	CONSTRUCTION Description (Naiden Surname)
lan	should be id Mental marked c metic eve	To B	BROOKS TAYLOR	MARGARET	GAUSS
Maryland 21215-0036	ges 1 and 2 should be filed within to f Health and Mental Hygiene. If item 27 Is marked other then or other treumetic event, The Mental	ľ		ing Address (Street and Number or Rural Route Numb	
	f Healt item 2		20a. Method of Disposition 20b. Place of Disposition		RG, MD. 21048 20c. Location - City or Town, State
Ē	Pages nent of I ent: If its ury or o		I Buriar 22 Cremation 3 Hemoval from State	Y CREMATION 9/1/05	SYKESVILLE, MD.
Baltimore,	permit. Pag Department Importent: I any injury o once.			2. Name and Address of Facility FLETCHE: 54 E. MAIN ST., WEST	R FUNERAL HOME
			23a. Part1. Enter the alsease, or complications that caused the death. Do not en shock, or heartfailure. List only one deuse on each line.	ter the mode of dying, such as cardiac or respirately a	Approximate Interval Between Onset and Death
j	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	le Myo Cardral	Infanctice
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	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) way	
	xecute and al-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):		
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9	ing physics the	Medi	IF FEMALE:		
Box	death certific e attending p ed for use as	ian/I	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	Ectopic pregnancy	23d. Date of delivery Month Day Year
o.	g o g	Physician/Me	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Unknown	Other (specify)	
ds, P	w requires that the s been signed by the should be detache	by	Part II. Dther significant conditions pontributing to death but not resulting in the	110 \$6.0	robacco use contribute to the cause of death? Yes 2 □ No 3 YProbably 4 □Unknown
Vital Record	w requires been sign should be	Completed	- December 1 december 1	24a. Was	
Re	(C)	omo	and dan lander a	auto	
/ital		BeC	25. Was case referred to medical examiner?	26. Place of Death (Check only	
of V	Physicien: r this certific ral director,	ပ္	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ER/Outpatie	The American Company of the Company	
on (ding I h. After funer	tion	27. Manner of Death 1 X Natural 5 □ Pending (Month, Day Year) 2 ↑ Accident investigation (28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at 28d. Describe Work? M 1 □ Yes 2 □ No	how injury occurred
Division	of or Attending after death. Director: After din by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		Street and Number or Rural Route Number, wn. State)
	urs aft erel Di				
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal control on the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and due to the vestigation, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number $D = 3015$	29d. Date signed (Month, Day, Year)
	ME		30. Name and address of person who completed cause of death (Item 23a) (Type,		9/1/0003
_	, p		D.S. KALARIA MD ZI7 WA	SHINGTON HEIS WE	ESIMINSTER, MO
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		2113/
	Registr	aı	SEP 0 2 2005 Stewn &	goarle	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepen 05 30357 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 2005 August 9:16 AM Mary Galbreath Tinsman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Bel Air Lorien at Bel Air If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth Month, Pay Year) 7/10/1909 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 🗗 F Mary land 219-78-5210 96 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County ehow. r than "natural", or items 23a or 28e-f ehovitie Wedical Examiner must be notified at 1 ☐ Yes 2 QNo Funeral Director MD Bel Air Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Apt 104 21015 U.S.A. 1909 Emmorton Road Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In home 11 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be for and Mental F marked Allen Nelson Galbreath Maude Devoe ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2371 Shuresville Rd. Darlington, MD item 27 I Mary Ella Kelly (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 9/1/05 ŏ Department of Important: If it eny injury or o 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State R. A. Ferris & Co., Inc. West Chester, PA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.
Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that dauled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS, HYPERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ASSISTE D P 1 🗌 Yes lhis LIVING funeral 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Hospitel or Attending 5 Pending 1 Natural investigation death. 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide after 24 hours a 29a. Certifier time Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

M

Baltimore, Maryland 21215-0036

P.O.

of Vital Records,

D45344

MD. 622 S. UNION AVE, HAVRE DE GRACE, MD 21078

Milliasken

31. Date filed (Month, Day, Year)

30. Name and address of person who/completed cause of death (Item 23a) (Type, Print)

09/01/2005

State of Maryland / Department of Health and Mental Hygiere 0 0 30358 1- State Registrar AMEND #23 per PHYS 9/2/05 DB Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 6:50 P 2005 Barbara Beverly VanSickel August 30. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 27179 Yowaiski Mill Rd. <u>Mechanicsville</u> St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days Aug. 29, Year 936 Illinois 9. Birthplace (State or Foreign **Funeral** Hours Min. 569-48-9632 1 M 20 F 69 Director Yrs. Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23e or 28a-f show the Medical Examinat must be notified at Maryland St. Mary's 1 ☐ Yes 2X No Directo Mechanicsville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 27179 Yowaiski Mill Rd. death v 20659 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify. Specify: 2 3 ☐ Widowed 4 ♣ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed within al Hygiene. 2 Cotlege (1-4or 5+) Elementary/Secondary (0-12) **Key Punch Operator** U.S. Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event 9008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Donald Glendening Beltz Margaret Loretto Hindert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Everett/sister 27179 Yowaiski Mill Rd., Mechanicsville, MD 20659 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State Sept. place) Brinsfield-Echols crematory 22. Name and Address of Facility Brinsfield-Echols Funeral Home, ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee P.A., 30195 Three Notch Rd., Charlotte Hall, MD LOK Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat/hailure. List only one cause of each line the mode of dying, such as cardiac or respiratory arrest, shock, or heat/hailure. List only one cause of each line the mode of dying, such as cardiac or respiratory arrest, shock, or heat/hailure. List only one cause of each line the mode of dying, such as cardiac or respiratory arrest, shock, or heat/hailure. List only one cause of each line the mode of dying, such as cardiac or respiratory arrest, shock, or heat/hailure. List only one cause of each line the mode of dying, such as cardiac or respiratory arrest, shock, or heat/hailure. List only one cause of each line the mode of dying, such as cardiac or respiratory arrest, shock, or heat/hailure. List only one cause of each line the mode of dying, such as cardiac or respiratory arrest, shock, or heat/hailure. List only one cause of each line the mode of dying, such as cardiac or respiratory arrest, shock, or heat/hailure. tmmediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner CEREBELLAR ATAXIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and be detached for use as the burial-transit The faw requires that the death certificate be executed HYPERTENSION Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical SEIZURE DISORDER IF FEMALE 23c. tf yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2 No 1 ☐ Yes Division of Vital Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Praesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After ! Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No after death Director: 2 Accident 6 Could not be 3 Suicide To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) N.K. Jayeraman MD 000 31344 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.K. Jayaraman, M.D., Mechanicsville, MD 20659 31. Date filed (Month, Day, Year) SEP 0 32. Registrar's Signature State 0 2 2005 Registrar

			1 - For State Registrar		State of N	Maryland	d / Depa <i>Cei</i>	artment of rtificate of	Health an Death	nd Mental H	ygien e Reg. No.		303	59
	Physici /Medi		1. Decedent's Name (First, Edwin		Daniel	7	Valle	jos		2. Date of E Month Augus	Day		3. Time o	
	Examir		4a. Facility Name (If not ins	ich Woo	ds Drive	e		Hyatt	or Location of C	Death	4c. Pr	County of Death	orge's	
	Funeral Director		5. Social Security Number 223-79-33 Usual Residence of Deced		M 2□F	Age (In yrs. Id 21	Yrs.	If Under 1 Yea Months Day		Min. (Month, L	irth Day, Year) 1198		place (State d intry) na , Pej	
	e Maryland e-fahow	ctor	MD 10a. State 10b. 0	ntgome	ery		,Town or Lo	Spring	J				10d. Inside C 1 ☐ Yes	ity Limits 2 ☑ No
	ath with th	Funeral Director	10e. Street and Number 1802 Moun	t Pisc	ah Lan	e #11	1	10f. Zip Code 209	903		1	izen of What Cou Peru	intry?	
5-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show important: If Item 27 is marked other than "hatural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at ODGs.	d by Fune	11. Marital Status 1] Married	2. Was Deceder Armed Forces 1 ☐ Yes 25 If Yes, Give Year or Dates	?] No		Was Decedent of f Yes, specify Cu 1 □XYes 2□ N	-	n? (Specify Yes or N Puerto Rican, etc.) Peru	lo-	14. Race - Ameri Black, White Specify: W		
21215-0	within 72 ho ene. than "natur he Medical	Completed by		cedent's Educ highest grade 0-12)		r 5+)	(Give life. I	lent's Usual Occ kind of work don DO NOT use retii tudent	upation e during most of ed)	f working	16b. Kind of Business/Industry School			
Maryland 2	should be filed and Mental Hygis Inmarked other	To Be C	17. Father's Name (First, N Ricardo F		jos				Rosa	Name (First, Middle C. Rocha	e, Maiden	iden Sumame)		
	1 end 2 sho Health and hm 27 la m		19a. Informant's Name/Rei Jessica Va 20a. Method of Disposition	, , , , ,			180	2 Mount	Pisca	or Rural Route Num ah Lane Date	#11	Silver	Spri	3 ng,Ml
Baltimore,	artment of Pages artment of Partment of Pages Injury or o		1 Burial 2 Crem 4 Donation 5 Ot		emoval from Stat	9	rdine		a Paz9	/09/200	5 Li		1	
Ba	Deparit. Deparit Import any Inj		23a. Part1. Enter the disea shock, or heart failure	Luck	ations that caus	ed the death	9	241 Co	lumbia	LDI FUND Blvd.S	ilve	SERVIC r Sprir	CE, P. A	20910
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	ſª.	Gun:		Woun		. /	l and C			Interval Bet Onset and I	
68760,	icate be executed in physicien and sthe burial-transit	edical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. c.		s a consequ								
P.O. Box 6	The law requires that the death certificate has been signed by the ettending plagge 2 should be detached for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 □ Yes 2 □ No 9 □ Unknown	rit	ic. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fetal	death 3 🗆	Ectopic pregnan Other (specify)	су		2	23d. Date of deliving Month	•	Year
	w requires that been signed b should be dete	þ	Part II. Other significant co	nditions cont	ributing to death	but not resul	Iting in the ur	iderlying cause g	iven in Part I.			se contribute to t	he cause of d	
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Vital		To Be	25. Was case referred to mexaminer? 1. Yes 2 □ No		ospital:	iont 2 🗆 E	R/Outpatien	3 □ DOA O	then	Death Check only	-	X	. at a	0000
O	nding Phys th. : After this s funeral di		27. Manner of Death 1 □Natural 5 □ F	ending	28a. Date of In (Month, D	jury ay Year)	28b. Time of Injury	28c. Inju	4 🗀 (4015)	ng Home 5 ☐ Res 28d. Describe			mals	cene
Division	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Certification:	3 ☐ Suicide 6 ☐ 0	Could not be etermined	28e. Place of I	-/	ne, farm, stre	eet, factory, office		28f. Location City or To	(Street and own, State)	d Number or Rura	al Route Num Pernuic Ville N	
	To the Hospital or within 24 hours after To the Funerel Director completely filled in	Medical	29a. Certifier 1 Ce (Check only one) 1 Me	rtifying Physi dical Examine	cian: To the bes er: On the basis and manner s	of examination	vledge, death on and/or inv	occurred at the estigation, in my	me, date and plopinion, death of	lace, and due to the occurred at the time	cause(s) , date and	and manner as s place, and due to	tated)
	With To To To To To To To To To To To To To	≥	29b. Signature and title of d	ertifier L HA	llan	md			.C.M.E.			e signed (Month, ust 27,		
-	•		CAROLt	+ Au	npleted cause of	Vd	111	Penn Str	eet, Ba	ltimore,	Maryl	land 212	01	
	Sta Registr	_	31. Date filed (Month, Day, SEP	0 1 20	32. Fegis	trar's Signatu	Tre	artie						

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygie 20 0 5 30360 1 - State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 3:50 P M 29, 2005 /Medica! Marie A. Vermillion August 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🖼 F Days Hours Director 578-38-8829 Nov. 22, 1929 Washington, DC Usuel Residence of Decedent Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f ahow any jury or other traumatic event, the Medical Examinat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 12510 Littleton Street 20906 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 William M. Smith Myrtle A. Connors 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pope V. Vermillion Husband 12510 Littleton Street Silver Spring, MD 20b. Place of Disposition (Name of cometery, crematory or other place)
Gate of Heaven 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Sep. 2, 2005 Silver Spring, Maryland Cemetery 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 20901 21. Signature of Funeral Service Licenses 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician witim disease or condition resulting in death) 4 day /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 physician a the burial Box 68760. Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant atter Live birth 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting, in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed2 2 1 No 1 Yes 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Tyes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 12 . No 1 Inpatient 2 ER/Outpatient 3□ DOA After the funeral 28a. Date of Injury (Month, Day Year) 27. Manuar of Death 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the hours after deat 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide within 24 hours a To the Funeral I illed 29a. Certifier 1 Exertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pennis, C. Friedman, M.D.(Rd 225 SH STOVE rockville 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 01 2005 SEP Registrar

Voland

Physicia /Medic Examin

Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiane. Important: if Item 27 is marked other than "natural; or Iteme 23a or 28a-1 show early injury or other traumatic event, the Modical Examinar mark be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

For State Registrar			of Maryland		artment of H		Re	g. No.	30361
. Decedent's Nan	ne (First, Middl	MICHA	EL KEN	NETH	VOLAND		2. Date of Death Month August	Day Yeer	3. Time of Death
a. Facility Name	(If not institution	n, give street and nu	mber)		4b. City, Town, or	Location of Death	n	4c. County of Dea	ath
		apsco River			Ellicott			Howard	
. Social Security 218-82-	-5373	6. Sex 1 1 M 2 □ F	7. Age (In yrs. I 45	ast birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 2 / 2 2 / 1	Year) C	rthplace (State or Forei country) RYLAND
Isual Residence of Oa. State	of Decedent 10b. County	,		, Town or Lo					10d. Inside City Limi
PA	A	dams	HA	NOVE	₹		γ.		1 □ Yes 2X
0e. Street and No	umber EE JAY	TANTE			10f. Zip Code	17331	10	g. Citizen of What C USA	Country?
1. Marital Status		12. Was Dec	edent Ever in U.	S. 13.	Was Decedent of H		pecify Yes or No-	14. Race - Am	
1 Never Mar	rried 2∑ Mar	If Yes, G	2X No ve No		If Yes, specify Cuba 1 ☐ Yes 2 No	n, Mexican, Puert Specify:	o Hican, etc.)	Black, Wh	ite, etc. VHITE
	15. Deceder	nt's Education est grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of wor	rking	6b. Kind of Busines	
Elementary/Sec	condary (0-12)	College (1-4or 5+)	шъ.	HANDYMA			MAINTENA	NCE
7. Father's Name	e (First, Middle,						ne (First, Middle, M		
		D CARROI	L VOLA			DORI			11080
19a. Informant's 1 SUZANNE		ship (Type, Print) DLAND -	WIFE		3		•	City or Town, State, PA. 17	
0a. Method of Di				ace of Dispo	osition (Name of matory or other place	e)	Date 2	0c. Location - City o	r Town, State
4 Donation	5 □ Other (S		ALL					YKESVILI	
21. Signature of F	Ineral Service	Licensee						FUNERAL INSTER,	HOME MD. 2115
23a. Parti. Enter	me disease, o	r complications that t only one cause on	caused the death						Approximate Interval Between
snock, or na Immediate Cause disease or conditi	(Final	only one cause on	(SA)	2~ t	Guarto	Flyne-	ent Ho	1	Onset and Death
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f any, leading to ause. Enter Und Cause (Disease of	immediate derlying or injury	Jue 10	(or as a consequ	ience or):					
hat initiated even esulting in death)	nts	c	(or as a consequ	ence of):					
		d							
F FEMALE: 23b. Was decede in the past 1	12 months? 2 □ No	1 Live	itcome of pregnal birth 2 D Fetal nant at time of de	death 3	□Ectopic pregnancy			23d. Date of di Month	eiívery Day Year
9 ☐ Unknow Part II. Other sign		ons contributing to o		ilting in the u	underlying cause give	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
							1 ☐ Yes	3 2 No 3 □ F	Probably 4 Unknov
							24a. Was an autopsy perform	prior to	utopsy findings availat completion of cause of
							Yes 2	□ No Ye	
25. Was case refe examiner? 1 XYes 2 [Hospital:	Inpatient 2 1	ER/Outpatie	nt 3 DOA Oth		ath <i>Check</i> o <i>nly one</i> Iome 5 ☐ Resider	3272	acifu) at scene
7. Manner of Dea	ath	28a. Date	of Injury	28b. Time o			28d. Describe hov		outy) at a second
1 ☐ Natural 2 ☐ Accident		igation round	8/29/05	06 19			Subje	A 8101	self
3 Suicide 4 ☐ Homicide	6 □ Could determ	ninod 200. Flac	e of Injury - At ho ling, etc. (Specify	me, farm, st	reet, factory, office		28f. Location (Street, City or Town,	eet and Number or F State)	Rural Route Number,
29a. Certifier		ng Physician: To th	asis of examinat						
(Check only	nd title of certific		nner stated.		29c. License	number	29	d. Date signed (Mor	nth, Day, Year)
	1 1/1	2 . 4				.M.E.		August 29	, 2005
(Check only one)	lox	eww)	1 - 1 - 1 - 1 - 1 - 1						
(Check only one)	dress of person	who completed cau	se of death (Item			t. Balti	more. Mar	vland 212	01
(Check only one)	lonw	KE MS	se of death (Item	111 P		t, Balti	more, Mar	yland 212	01

State Registrar

30362 State of Maryland / Department of Health and Mental Hygie [] [5 Amend Item 26 per Dr., G848 10 112 105 hbeath 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** August 29, 2005 Russell Vara 8:35 p ^M Philip /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 10XM 20 F Director 090-26-6718 May 28, 1936 New York 69 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2√2 No VA Directo Fairfax Falls Church 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3873-A Steppes Court 22041 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 XYes 2 No If Yes, Give Year or Dates: Korean 1 ☐ Yes 2 TNo Specify: White Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Hotel Sales Marketing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Vara ပ Providence Zuzze 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6916 Race Horse Lane <u> Christian G. Vara - Son</u> Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 09/04/2005 Herndon, VA Adams-Green Funeral 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 721 Elden Street Herndon, VA 20170 Adams-Green Funeral Home nin Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Archy Thmia Physician entricular minute resulting in death) /Medical Due to (or as a consequence of): Examiner ardiac Isclema Sequentially list conditions, a y leading L immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Dronav Due to (or as a con equence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Int An 36 Division of Vital Records, à Voiscuku 1 Yes 2 No 3 Probably 4 WUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? paga certificata 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No diractor, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient Other: 4 Nursing Home 5 nesidence 6 Other (Specify) 1 Tes 2 No 2 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27 Manner of Death 28b. Time of After 5 Pending 1-Natural 1 Tyes 2 No death. investigation 2 Accident 1 Diractor: d in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a To the Funeral [filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the ! 29b. Signature and title of certifier 29c. License number Virginia 29d. Date signed (Month, Day, Year) 8/31/05 MD 0101 226093 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22201 1715 North George Muson Dave Suite 307 Tim Mun, MD 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State AUG 31 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 0 0 5 30363 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Marv Veltri September 5,2005 1:28 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Jan. 18, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Yrs. Director 84 177-18-0890 1921Pennsylvania Usual Residence of Decedent 10a State 10b Counts 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Yes 2 No St. Mary's Leonardtown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a Apt# 2112 22680 Cedar Lane Court 20650 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Itei Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No <u>م</u> Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Food Processor Food Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lorenzo Altobelli Carmila DeMarco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Eural Boute Number, City or Town, State, Zip Code) Janis R. Hunt (Daughter) Mechanicsville, Maryland 20659 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 2005° 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Monongahela Cemetery | Sept. 10, Monongahela, PA 22. Name and Address of Facility
Brinsfield Funeral HOme, P
Leonardtown, MD 20650-0279 21. Signature of Funeral Service Licensee, Kyle S. Simons M01206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician liver disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner liver Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. signed by 1 I be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 文Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed: of Vital 2 **N**0 Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After Division 1 Natural 2 Accident s after dec. 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 47066 6.05

Registrar

DHMH 17 Rev 1/2001

State

22650 Cedar Lane Court, Leonardtown, Maryland 20650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist

2005

Avani D. Shah, M.D.,

31. Date filed (Month, Day Year)

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	death with the Maryland ms 23e or 28e-f show Intust be notified at	ctor	Usual Residence of Decedent 10a. State 10b. County MD PG	10	Oc. City, Town or I		1 09/	U1/ 1948 	Pe	10d. Inside City Limits 1 ☐∰es 2 ☐ No
	th with the 23e or 28 ust be no	Funeral Director	10e. Street and Number 1333 Nalley Terrace			10f. Zip Code 20785		10g.	Citizen of What C	country?
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yland 2	should be filed with and Mental Hygiene marked other the matic event, The	To Be Co	17. Father's Name (First, Middle, Last) Corneilus Dalton Par	cker		18.	Mother's Name (First, Eupha Juani	ta Wrig	de <i>n Sumam</i> e) ht	
	l and 2 sh fealth and im 27 is in her traum		19a. Informant's Name/Relationship (7 Neil Watson — Son		1333	Nalley Terrace	e; Hyattsvil	le, Mary	yland 2078	85
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic anges.		20a. Method of Disposition Disposition Under Specify 21. Signature-qf#Operal Service License	Removal from State	Maryland W	eteran Cem	09/07/2005		Location - City or eltenham, 1	
Ba	permit. Departr Imports any inje		> Gendan	reeman)	P.O. Box 416;	Suitland, Ma	ryland	Services 20752	Approximate
68760,	death certificate be executed with the physician and be attending physician and dor use as the burial-transit	edical Examiner	23a. Part1. Entay the disease, or content shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	Aue to a consequence of):	and a	eis Resociat		schroderm	Interval Between Onset and Death
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	To the Hos within 24 ho To the Fun completely i	Medical	(Check only 2 Medical Exami	ner: On the basis of exa and manner stated.	y knowledge, deat	th occurred at the time, da evestigation, in my opinion 29c. License num	, death occurred at the	time, date a	(s) and manner as nd place, and due Date signed (Monti	to the cause(s)
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4	(6)		30. Name and address of person who co	Registrar's S	CT, MD	Prince	Georges' 1	tospit	al; Che	verly, MD
	Sta Registr		SEP 0 2 2005	Sleeve !	A Apo	le				J

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 1 - For State Registrar 30365 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 26,2005 Year **Physician** Mary Wilbanks Aug. 11:15 8 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death
PRINCE GEORGE'S Examiner 4b. City, Town, or Location of Death RIVERDALE Crescent Cities 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 7–22–1933 **Funeral** Birthplace (State or Foreign
Country) Year) 1 □ M 27 F 121 28 9381 72 Director Yrs Arkansas Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Joyn of oration 10b. County 10a, State ral', or itams 23a or 28e-f ahow Examiner roust be notified at 10d. Inside City Limits Director XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1022 8IH SIREET NE 20002 U.S.A. Completed by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Specify: BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 5YRS llege (1-4or 5+) al Hygiene. Elementary/Secondary (0-12) **TEACHER** SCHOOL SYSTEM othar traumatic avant, 17. Father's Name (First Middle Last) Be 18. Mother's Name (First Middle, Maiden Sumame) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5508 43RD PLACE HYAITSVILLE, MARYLAND 20781 Department of Health a Importent: If item 27 is any injury or othar tra TARA C. WILBANKS/ DAUGHIER 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State RIVERDALE CREMATORY 08-31-2005 RIVERIALE, MARYLAND 5 Other (Specify) 21. Signature of 5 neral Service Licensee 3015 12TH CTOLLER NE WASHING ame and Address of Facility JOHN T. RHINES FUNERAL HOME CO. 12IH SIREET NE WASHINGION, DC 20017 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metaslatic **Physician** Breast- Cances disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 Other (specify) the 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No this certificate has autopsy performed? 1 Yes 2 X No funeral director, 25. Was case referred to medical 26. Place of Death Check only one) examiner? Other: Certification: To 1 ☐ Yes 2 No 4XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death nours after death.

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filled in by the funera 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D48213 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Neelau Achai 4410 7416 Ave landoversing MD 20784 Ashori 31. Date filed (Month, Day, Year) . Registrar's Signature State SEP 0 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 05 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) AUGUST 4:00 P M **Physician** 2005 WOMACK /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
April 10 1943 VIRGINIA 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours Months 10XM 20 F Director 212-40-3418 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show traumatic avant, the Medical Examinar must be notified at 1 XYes 2 No Director PRINCE GEORGE'S FT. WASHINGTON MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20744 7203 WOOD HOLLOW TERRACE U.S.A. or itams 23s 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ BLACK 3 Widowed 4 Divorced "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) AUTO TECH PRIVATE 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Itam 27 is marked othany injury or othar traumatic avant Be THELMA D. WATSON ERRIN WOMACK SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20748 5110 Taft Road Camp Spring Maryland IRVIN WOMACK JR./BROTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Incremation 3 ☐ Removal from State RIVERDALE CREMATORY 9/6/05 RIVERDALE, MARYLAND ' 4 ☐ Denation 5 ☐ Other (Specify) 2 Signature of Frineral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE PERITONITIS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, bearing to in modiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Examiner certificate be executed burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown LUNG CANCER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 2 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Director: Alter 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospitel or At within 24 hours after d To the Funeral Direct determined 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 050862 Stund Hour, MD SEPTEMBER, 1, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sherif Hassan M.D. 9831 Greenbelt Road # 103 Lanham, Maryland 20706 31. Date filed (Month, Day, Year) 3 Registrar's Signature State **SEP 0 2 2005** Registrar

State of Maryland / Department of Health and Mental Hygie pen 05 30367

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Director permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "naturel", or Items 23a or 28a-f ehow any injury or other traumatic event, Ita Mudical Exartment the notified any injury or other traumatic event, Ita Mudical Exartment the notified as

Baltimore, Maryland 21215-0036

/Medical

Physician Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours elater death.
To the Funerel Director: After this certificate has been signed by the ettending physicien and completely filted in by the funeral director, page 2 should be detached for use as the buriat-transit

Division of Vital Records, P.O. Box 68760,

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State Registrar

State of Maryland / Department of Health and Mental Hygiene 30368 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Wadde11 2005 /Medical Aug. 31. 9:34 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert 7. Age (In yrs. last birthday)

50 Yrs 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🛣 F 220-62-8457 Director Oct. 29, 1954 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f ahow 10d. Inside City Limits the Medical Examiner must be notified at Maryland Calvert St. Leonard 1 ☐ Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ö 238 1329 Flag Harbor Blvd. 20685 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 12 Mortgage Companies Loan Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph Ignatus Windsor ဥ Della Catherine Biggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Depertment of Health ar Important: If item 27 Is any injury or other trau St. Leonard, MD 20685 Robert Waddell, Sr./husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Sept. 1, 1 Burial 2 Cremation 3 Removal from State Brinsfield-Echols crematory 2005 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A., 30195 Three Notch Rd., Charlotte Hall, MD 23a. Part 1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause or each line. Approximate 20622 Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** metastahe breast concer 5 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of). Examin The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the the as nding p 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No tor: After this certific the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 3 Suicide 6 Could not be determined within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 56024 the August 31 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Frederick MI) Suite 110 Kenneth L. Abbott 110 Hospital Rand 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State SEP 0 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 30369 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death August **Physician** 30 2005 11:00 AM Daniel Wolff /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 14510 Homecrest Road Apt 2012 Silver Spring | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 14,1928 Birthplace (State or Foreign Country)
 New York 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F Yrs. 77 Director 264-38-0177 Usual Residence of Decedent within 72 hours efter death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r then "naturel", or items 23a or 28e-f show the Medical Examiner roust be nutitied at 1 ☐ Yes 2X No Director Silver Spring MOntgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 14510 Homecrest Road Apt 2012 20906 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII WHITE 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 X Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Car Salesman Automobile 12 should be filed w h and Mental Hygier I is marked other th Pages 1 and 2 should be filed v itment of Health and Mental Hygie rient: If Item 27 is marked other t ijury or other treumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Unavailble Herbert Wolff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Paula Wolff / Daughter 7819 Overhill Road, Bethesda ,MD 20814 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Metropolitan AUGUST 2005 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State infuryor Department o Importent: If any injury or ' 4 ☐ Donation 5 ☐ Other (Specify) Crematory Alexandria, Virginia permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home, 10 East Stru Deer Park Drive, Gaithersburg, MD 20877 IRACU 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ARTERIOSCLEROTIC HEART DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician. Be Completed by Physician/Medical been signed by the attending phys should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2**X** No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation efter death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) I in by 4 Homicide Hospitel within 24 hours To the Funerel filled 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D0056986 Zingi, MI 141 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7500 Hanover Parkway Suite 105, Greenbelt, MD 20770 Chalak Berzingi M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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2005

State of Maryland / Department of Health and Mental Hygiene [] 5

Certificate of Death Reg. No. 2. Date of Death Month C 3. Time of Death Year 2305 05

 Physician /Medical Examiner

Director the Maryland

Department of Health a Importent: If item 27 is eny injury or other tree

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

burial-transit requires that the death certificate be executed physician Box 68760 the P.O. the ģ Division of Vital Records, To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certified

51 State Registrar

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) JAMES ALLEN WIKE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death CARROLL CARROLL HOSPITAL CENTER WESTMINSTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1**∑** M 2□ F Months 55 216-52-5466 1950 MARYLAND JUNE Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Pages 1 and 2 should be filed within renew...
iment of Health and Mental Hygiene.
iment of Health and Mental Hygiene.
itent: if item 27 is marked other then "naturel", or Items 23s or 28e-f show
tent: if item 27 is marked other then "naturel", or Items 23s or 28e-f show 1 ☐ Yes 2 🛣No CARROLL UNION BRIDGE MD Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21791 1540 BAUST CHURCH ROAD U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: WHTTE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CONCRETE FINISHER CONCRETE 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY CATHERINE CARR WILLIAM FRANK WIKE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), 1 7 9 1 19a. Informant's Name/Relationship (Type, Print) MICHAEL ARBAUGH - NEPHEW 1540 BAUST CHURCH RD. UNION BRIDGE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State CARROLL CREMATION 8/31/2005 HAMPSTEAD, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
MYERS-DURBORAW 21. Signature of Funeral Service Licensee FUNERAL HOME, P.A. M01191 91 WILLIS ST. WESTMINSTER, MD 21157 23a. Palt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 ASTROINTESTINA Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Examiner Due to (or as a consequence of) Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: ပ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 26290 0 295 STONEA 30. Name and address of person of death (Item 23a) (Type, Print) RISTIAN 31. Date filed (Month, Day, Year) 32. Re strar's Signature

AUG 3 1 2005

ate of Maryland / Department of Health and Mental	Hygiene nn =	303
Certificate of Death	Reg. No.	303

Willie	B. Wi	11:	Lams 1 - State Registrar	State of Ma	aryland / Dep	artment of h	Health and M			5 30	371
	Physic		1. Decedent's Name (First, Middle,	Last) Villiams, Jr		Timeate of		2 Date of Death	Day 2005	3. Time 3: 5	e of Death
	/Medi Exami		4a. Facility Name (If not institution, 7508 Greer Dri	give street and number)		Fort Wa	or Location of Death ashington		Prince	George'	s
	Funeral Director		5. Social Security Number 578–02–2108 Usual Residence of Decedent	5. Sex 7. Ag 1 ★ 2 ☐ F	e (In yrs. last birthday 40 Yrs.	Months Days		8. Date of Birth (Month, Day, Y 12/06/19	964	9. Birthplace (Sta Country) Florida	te or Foreign
	Maryland a-f show	ctor	10a. State 10b. County MD P. G	; •	10c. City, Town or L	ocation Jashingtor	n				e City Limits
	ath with the 23a or 28	Funeral Director	10e. Street and Number 7508 Greer Driv				0744		U.S.A	١.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I've Medical Exact at must be routiled at applies. Once.	by Fune	11. Maritat Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? d 1 Tyes 2 Ty If Yes, Give Year or Dates:		. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black	· American Indiar c, White, etc. Black	i.
Baltimore, Maryland 21215-0036	ithin 72 house.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12th	Education grade completed)	(Giv		during most of work ad)	ing 16	b. Kind of Bus	siness/Industry	
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Maryla	d 2 should th and Mei 7 is mark traumatic	2	Willie B. Will 19a. Informant's Name/Relationshi Jacqueline E. W	p (Type, Print)			rand Number or Run rive; Fort	al Route Number, C	City or Town, S		
nore, l	ages 1 and ant of Heali it: If Item 2 y or other		20a. Method of Disposition 1 Strial 2 Cremation 4 Donation 5 Other (Sp.	3 □Removal from State	20b. Place of Disp cemetery, cre	position (Name of ematory or other pla	ace)	Date 20	c. Location - (City or Town, State	
Baltir	permit. F Depertme Importar any Injur		21. Signal of Funerat Project	4		22. Name and Addre	ess of Facility Fr 416; Suit]	reeman Fur	neral S	Services	
	Physician /Medical Examiner		23a. Part Letter the disease, or of shock, or heart failure. List of trimediate Cause (Finat disease or condition resulting in death)	Alv dne cause on each li	ne.	nter the mode of dyi		or respiratory arrest	t.	Approxin tnterval Onset a	mate Between nd Death
.760,	ate be executed hysicien and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):						
P.O. Box 6876	Attanding Physician: The law requires that the death certificate treath. setor: After this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the by	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	2 Fetal death 3	□Ectopic pregnanc	Э		23d. Date Mon	of delivery th Day	Year
	uires that the signed by ald be detacted	ğ	Part II. Other significant condition	ss contributing to death b	out not resulting in the	underlying cause gr	ven in Part I.			bute to the cause	
Division of Vital Records,	Physician: The law requires this certificate has been signi al director, page 2 should be	Completed						24a. Was an autopsy performe	d? de	/ere autopsy findin flor to completion of eath? ✓Yes 2 □ No	gs available of cause of
ita	ian: rtifica	Be	25. Was case referred to medical				26. Place of Deat	h (Check only one)			
>	nysic iis ce direc	10	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatio	ent 2 ER/Outpatie	ent 3 DOA Ct	her: 4 🗆 Nursing Ho	me 5 Residenc	ce 6 Jothe	r (Specify) Scel	ne
ionoi	il or Attending Phy after death. Diractor: After this d in by the funeral d	ertification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ation 8/25/0	y Yeer) tnjury	Wo	ry at ork?] Yes 2 ⊈No	28d. Describe how	intury occurre	d	
Divis	or Atte	ertific	3 ☐ Suicide 6 ☐ Could no determine	ned 288. Place of in	iury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (Stree City or Town, S	State)		

To the Hospital or Attending Physician: The law requires that the

5 Pending investigation SUBJECT 3:40 P 1 ☐ Yes 2 💆 No 8125105 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide RESIDENCE

28f. Location (Street and Number or Rural Route Number, City or Town, State) 7508 GREER OF, FT MASHINGTON, KD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number

August 26,2005 OCME

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RUBIO, MD 111 Penn Street Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year) AUG 3 1 2005



within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

filled in by

Medical

			For State Registrer	State of Marylar		artment rtificate				Re	g. No.	5	303	
	Physici	an	Decedent's Name (First, Middle, Last)						2	2. Date of Death Month	Day	Year	3. Time of	4.4
	/Media		Frederick James W			45 City 7		t continue of		August	28 2 4c. County	2005	1515	5
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	h the	Funeral Director	10e. Street and Number			10f. Zip	Code			10	g. Citizen of V	What Cour	itry?	
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	r dea	nei	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13.	Was Decede If Yes, speci	ent of His rfy Cubar	spanic Origi n, Mexican,	in? (Speci Puerto Ri	ify Yes or No- ican, etc.)		e - Americ k, White,		
36	s afte	by F	1 Never Married 2 Married 3 ⊠Widowed 4 Divorced	1 X Yes 2 □ No A TT If Yes, Give Year or Dates:	ny	1 ☐ Yes 2	ol X []	Specify:			Specify	Bla	ck	
8	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene 1 the Alter 1 is marked other than "natural", or liems 23a or 28a-f show other traumatic event. It a Medical Examinational be notified at	ed t	15. Decedent's Edu		16a. Dece	dent's Usua	I Occupa	tíon		1	6b. Kind of Bu	usiness/in	dustry	
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Baltimore,	0 = 5		20a. Method of Disposition 1 □Burial 2 □ Cremation 3 □ R	emoval from State	cemetery, crei	matory or ot	her place					•		
Ħ			'4 □Donation 5 □ Other (Specify)		orgetow	n Cem		-	/2/20	005 1	Pocomok	e, M)	
Ba	permit. Page Department o Important: If any Injury or once.		21. Signature of Euneral Service License	90	Te	wis N	Wa	tson	Funei	ral Home	9			
	STATE OF		anti. Inter the disease, or compli	cations that caused the dea	th. Do not en	ter the mode	ST R	a. Such as c	alist ardiac or	respiratory arre) 21801 st,	- 1	Approximat	te
	Physician American physician physician physician physician and physician phy	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect of the conse	hwich quence of):	ule w							Onset and	
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rds, P.	w requires that been signed t should be det	ed by P	Part II. Other significant conditions cor	stributing to death but not re-	sulting in the u	inderlying ca	use give	in in Part I.		23e. Did tob	acco use conti s 2 No		ne cause of d ably 4 🔲	
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Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	In a site la					of Death /	Check only one	2			
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	ding After fune	ation;	27. Manner of Death 1 ★ Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	M 28	8c. Injury Work 1 🗆 Y	at ? ∕es 2 □ N		ld. Describe ho	w injury occurr	700		
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	Regist			005	K	Last.	e							

State of Maryland / Department of Health and Mental Hygie 20 0 5 30373 For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Arthur 30, Aug 10:20 a^M Morrison 2005 Woodburn, Jr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Univ. of Maryland Medical Syst Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) Months Days Hours 1⊠M 2□F 77 215-22-2228 Director May 18, Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland | Anne Arundel Millersville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Items 23a 433 Ayrlawn Drive 21108 USA Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "naturel", or Items 23. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Terminal Foreman 12 Oil Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Morrison Woodburn, Sr. ပ Nettie Bond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn C. Woodburn/Wife 433 Ayrlawn Drive, Millersville, Maryland 2110d other t 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion United Methodist 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit, Page Department of Important: If any injury or 4 Donation 5 Other (Specify) Sep 2, 2005 Mechanicsville, Maryland Cemetery 21. Jature of Funeral Service Ligensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P. O. Box 270, Leonardtown, Maryland 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician aGun Shot To Head /Medical Due to (or as a consequence of): **Examiner** CERTIFICATION APPROVED BY MEDICAL EXAMI Sequentially list conditions, if any, leading to immediate cause. Each interpretation of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner?

X Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27, Manner of Death 28d. Describe how injury occurred Certification; After 8 / 30 / 05 Year) 5 Pending investigation 1 Natural 091906 am 1 ☐ Yes 2 💆 No Subject shot self death. 2 Accident Director: d in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, 433 Ayrlawn Drive X Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide HOME 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and financer as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 124 hours a 29a. Certifier Medical within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Sept. 2, 2005 DO062292 30. Name and address of person who completed a use of death (Item 23a) (Type, Print) Dr. Gregory York) 42 S. Greene Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) gistrar's Signatur State 8 2005 Registrar

State of Maryland / Department of Health and Mental Hygie 0 5 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** AUGUST 2005 1:50 A M WARNER 30 OLIVE /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COLLINGTON NURSING HOME MITCHELLVILLE PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye JUNE 15 9. Birthplace (State or Foreign **Funeral** Days Hours Min. Year 1 ☐ M 2 🖾 F NEW YORK 95 Yrs. -1910 JUNE Director 060-05-6279 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23e or 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Director MD PRINCE GEORGE'S MITCHELLVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2011 FOX MEADOW WAY 20721 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify 2 3 XWidowed 4 □ Divorced **BLACK** "naturel", 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done di life. DO NOT use retired) during most of working 12 should be filed within 7 h and Mental Hygiene. 7 is marked other then "r College (1-4or 5+) Elementary/Secondary (0-12) 12th **SEAMSTRESS** PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WILLIAM S. NICHOLS LILLIAN ROSSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 si if Health an item 27 is r 2011 FOX MEADOW WAY MITCHELLVILLE, MARYLAND 20721 WARNER/DAUGHTER ANDREA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ment of F tent: If its 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. LAUREL, MARYLAND * 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND NATIONAL 9/6/05 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Immediate Cause (Final Physician Arteriosclerosis disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Lymphedema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner certificate be executed use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Anemia the attending physician and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical Alzheimer d IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No jo Month Dav Year 5 Other (specify) 4☐ Pregnant at time of death detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à Dementia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy performed? 1 ☐ Yes 20 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 0 1 ☐ Yes 2X No 1 Inpatient 2 ☐ ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury at Work? After the Hospitel or Attending 5 Pending investigation 1 Natural after death. М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) 29c. License number D46834 2005 August 31, Desn 30. Name and address of person who completed caus if death (Item 23a) (Type, Print) 7525 Greenway Center Drive # 113 Greenbelt, Maryland 20720 Mary Lopez M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 3 1 2005 Registrar

State of Maryland / Department of Health and Mental Hygiefe 15

For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 27, AUGUST 2005 ROBERT WOLK 2:20 P WILLIAM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY VILLAGE HEALTH CARE CENTER MONTGOMERY VILLAGE MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | MARCH 6, 1969 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1**X** M 2□ F VIRGINIA 213-08-8085 36 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo MARYLAND MONTGOMERY BROOKEVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 20833 UNITED STATES permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Itams 23e enry injury or other traumatic event, Ital Mental Englishment 2308 ROSEBRANCH COURT Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married ☐Yes 2X No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) MANAGEMENT FLOWER SHOP 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be SUE SNYDER WOLK BARBARA STANLEY STEVEN ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DEBORAH EARNEST, 2308 ROSEBRANCH COURT, BROOKEVILLE, MD WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition remation 3 □Removal from State 1 X Burial 5 Other (Specify) GDN OF REMEMBRANCE CEM 8/30/2005 * 4 Donation 21. Signalare of Fyneral Service License 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final 6 KNG GOZ Pnysician MRAID disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (cisease of ir jury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law raquires that the death cartificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown ò signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 🗆 Yes 2 No 1 TYes Division of Vital Physicien: director, Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4.2 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 🗶 No this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Hospitel or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the the within 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title certifier 2 40051280 8-24-200 30. Name and address of person who complete cause of ath (In-m 23a) (Type, Print) ANUSHIRAVAN DADGAR, M.D., 13219 EXECUTIVE PARK TERRACE, GERMANTOWN, MD 20874 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 3 1 AUG 2005 Registrar

			1 - For State Registrar	State of	Maryland	/ Depa	artment of H rtificate of L	ealth a Death	and Mental Hy	gie 7 e00	5 303	376
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	/Medic Examin		4a. Facility Name (If not institution, gi				4b. City, Town, or		f Death	4c. County		
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	Funeral Director			1□M 2√2F	84	Yrs.	Months Days	Hours	Min. (Month, Da Aug. 1	Year) 1, 1921	9. Birthplace (State Country) Maryland	1
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٥	s 1 and 2 should be filed within 72 hours efter death with the Maryland if Heathi and Mental Hygiene. item 27 le anaked other than "natural", or Items 23a or 28e-f show item 27 le anaked other than "natural", or Items 23a or 28e-f show other treumatic event, Ite Medical Exaciliar must be ricitified at		1 ☐ Never Married 2 ☐ Married	Armed For	ces? 2 No	+	if Yes, specify Cuba 1 □ Yes 2 No	n', Mexican' Specify:	, Puerto Rican, etc.)	Specify	k, White, etc.	
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ອົ ອົ	and 27		Laura Fornwald (Daughter	10):		SOCKY RIG	ge, ko	ad, Thurmon		1 / 88 City or Town, State	
וסר	Pages nent of the ent: If its		1 X Burial 2 ☐ Cremation 3 1 1 ☐ Donation 5 ☐ Other (Special Control		State cen	netery, crei	matory or other plac n Mem. Ga				ck, Maryl	
Baltimore,	permit. Pages 1 Department of H Importent: If itel any injury or ott		21. Signature of Juneral Service Lice		244	Ŕ	Shame and Address	DATLE DATLE	Y & SON FUI	NERAL HO	MES, PA	
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Вох	death certific e attending p ed for use as 1	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐Live bi	come of pregnanc inth 2 ☐ Fetal d ant at time of dea	eath 3	Ectopic pregnancy Other (specify)			23d. Dat Mor	e of delivery nth Day	Year
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Division of Vital Records,	or Atte	Certification:	3 Suicide 6 Could not 4 Homicide determine	d 200. Flace	of Injury - At hom ig, etc. (Specify)	ie, farm, sti	eet, factory, office		28f. Location (City or To	Street and Number vn. State)	er or Rural Route N	umber,
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	the Ho in 24 the Fu npletel	Medical	one)	aminer: On the ba and mann	isis of examinationer stated.	and/or in			th occurred at the time,			
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	ابدا		30. Name and address of person who	o completed cause	e of death (Item 2	23a) (Type,	Print)			1.10	· S	
	J+1		Robert L. Kaufma 31. Date filed (Month, Day, Year)	nn, MD	300 West	9th	Street,	Frede	rick, Maryl	and 2170	01	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 0 5 30377 State Registrar Amend# 1.Per Phys.PGC 9-2-05 cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6:08 A M BERTHA M. ZAHARIS **Physician** tugust Zharis-Bertha--Ma /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Doctors Community Hospital Lanham If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F Months 94 Director 511-07-8911 September 17,1910 Kansas Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event. It a Modified at Maryland Prince Georges Riverdale 1MYes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20737 5309 Riverdale Road Apt. 412 United States Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White altimore, Maryland 21215-0036 Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than College (1-4or 5+) Elementary/Secondary (0-12) Primary Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be be la Jacob Kpeutzer Rosa Dreher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If item 27 is any injury or other traugues. Leonidas N. Zaharis/Son 5309 Riverdale Road Apt.412, Riverdale,MD 20737 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State George town of thiversity August Medical Center 2005 29 1 Burial 2 Cremation 3 Removal from State Washington, D.C. * 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, I P.O. Box 58007 Washington, D.C. 20037 21. Signature of Funeral Service License Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic breast **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran the death certificate be execu Due to (or as a consequence of): attending physician for use as the buria Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9□ Unknown o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar page 2 autopsy perform 250 No 21 No 1 Yes 1 Yes funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Anpatient 2**X**No 2 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Certification; 1 Natural 2 Accident 5 Pending after death.

I Director: Af d in by the fur 1 □ Yes 2 □ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours : To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Hanover Parlmay Greenbelt Maryland 20776 Anand, 31. Date filed (Month, Day, Year) SEP 0 2 2005

M.D.

of person who completed cause of death (Item 23a) (Type, Print)

30. Name and address

D-33482

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			1. Decedent's Name (First, Middle, Las	it)				2. Date of D	Peath		3. Time of Death
	Physici /Medio		Vivian A.	Abare				Septem	ber 12	2005	3:30p M
)	Examir		4a. Fecility Name (If not institution, give			4b. City, Town,	or Location of		4c. County		
			951 Richwood Road	1. Apt. C		Bel Ai	ir		Harf	ord	
	Funeral		5. Social Security Number 6. Se	7. Age (/	n yrs. last birthday)	If Under 1 Yea	r If Under 2		irth	9. Birthp	ace (State or Foreign
	Director		215-14-4733	□M 2X1F	34 Yrs.	Months Day	s Hours	July 2	29 1921	Coun	MD MD
	D _		Usuel Residence of Decedent								
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	ee e	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of	Hispanic Orig	in? (Specify Yes or N. Puerto Rican, etc.)		e - Americ	
9	or le	F.	1 Never Married 2 Married	1 ☐ Yes 2 XNo If Yes, Give	1	1 □ Yes 2 ☑ N		, r derto riican, etc./		ck, White,	erc.
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Jar	2 sh and le m		19a. Informant's Name/Relationship (7					r or Rural Route Num			
	end 2:		Vernon A. Jenkins				erry R	oad, Marie			
20	Pages 1 nent of H int: If its iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐			natory or other pl	, ,	Date	20c. Location	•	
Ë	men men tant:		4 ☐ Donation 5 ☐ Other (Specify		Chesapeake	Crematory	Inc 9	/14/2005	Belts	/ille	, MD
Baltimore,	permit. Pages 1 end 2 Department of Health a Important: If Itam 27 le eny injury or other tra 20028.		21. Signature of Funeral Service Licen	- A	1443 G	AFA, Ste	ephen D	. Lohrmann ures Drive	n, PA	, MD	21286
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Box	atter for u	clar	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at tim	Fetal death 3	Ectopic pregnan Other (specify)	су			te of delive onth	ry Day Year
P.O.	that the ded by the deteched	iysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		g cardi (specify)					
Δ.	that the ed by detect		Part II. Other significant conditions or	ontributing to death but n	ot resulting in the u	nderlying cause g	liven in Part I.	23e. Did	tobacco use conf	nbute to the	e cause of death?
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Ξ	fre d	E	4 Homicide determined	28e. Place of Injury building, etc. (3	- At home, farm, str S <i>pecify)</i>	eet, factory, office	9	28f. Location City or To	(Street and Numb own, State)	er or Rural	Route Number,
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	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours effer deeth. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be deteched for use as	Medical	29a. Certifier (Check only one) Certifying Ph. 2 Medical Exam	ysician: To the best of m iner: On the basis of ex and manner stated	am≀nation and/or in	n occurred at the vestigation, in my	time, date and opinion, death	d place, and due to the h occurred at the time	e cause(s) and ma , date and place,	anner as sta and due to	ated. the cause(s)
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i	9		30. Name and address of person who	completed cause of deat	n (ttem 23a) (Type	Print)				- 3)	
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State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Evon L. Burns September 18, 2005 7:30 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Riverview Care Center Essex Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 1 ☐ M 2 🕱 F Days Hours 219 10 6619 Director Yrs Oct. 15, 1923 North Carolina Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f ehow 10d. Inside City Limits Item 27 is marked other then "natural", or iteme 23a or 28a-1 ebov other traumatic event, Ite Medical Examinar must be notified at 1 Yes 2 No Directo Maryland Baltimore Essex 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1608 Gail Rd. "Apt 2" 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours atter. Department of Health and Mental Hygione. Important: If tem 27 is marked other than "natural", or then any Injury or other traumatic event Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify þ Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lee Bare Mary Jane Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Bolling (Daughter) 925 Oakleigh Beach Rd. Baltimore, Md. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9-22-05 * 4 □Dopatjon 5 □ Other (Specify) Bel Air Mem. Gardens Bel Air, Maryland 21. Signature of Funeral Services 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. prications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Part1. Enter the disease, or corpushock, or heart failure. List only Approximate
Interval Between
Onset and Death
Com ~ KNOON Immediate Cause (Final disease or condition resulting in death) **Physician** an /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Records, P.O. Box 68760. attending physician Physician/Medical the 88 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day 4□Pregnant at time of death 5 Other (specify) be detached signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 2 No certificate 1 Yes 1 ☐ Yes 2 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours atter death.

To the Funeral Director: Atter this certifica completely tilled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 1 Tes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and tille of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Pring MALIKA WASEM. 709. 12 BLVD -ASTBEN 31. Date filed (Month, Day, Year) 32 Registrar's Signature State SEP 1 9 2005 Registrar

State of Maryland / Department of Health and Mental Hygiener 1 - For State Registrar 30380 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Year Marie Catherine Baker 9:15A^M September 15, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale Baltimore Manor Care Rossville If Under 1 Year If Under 24 Hrs. 8. Date of Birth
House Pours Min. 8. Date of Birth
(Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X** F 90 Yrs Director 215-01-8789 1/1/1915 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show Maryland Baltimore Rosedale Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 7930 35th Street iteme 23a 21237 U.S.A. death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ (XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🙀 No Specify: White 3 XWidowed 4 □ Divorced "natural" the Modical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Payroll Clerk 8th and Mental Hygie Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George J. Skarda Katherine Lipa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 ie any injury or other trau Marie Baker/daughter 7930 35th Street Rosedale, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 9/19/05 4 □ Donation 5 □ Other (Specify) Baltimore, MD 22. Name and Address of Facility Cvach/Rosedale Funeral Home 21. Signature Inera S rvice Licensee 1211 Chesaco Avenue Rosedale, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter or destroing Cause (Disease or injury Examine Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy atter for u in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. F 9□ Unknown 9 Unknown Part II_Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Š Hends 15 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificete 1 🗌 Yes 1 Yes 2□ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other Certification: To 1 Tyes 3□ DOA Nursing Home 5 Residence 6 Other (Specify) this After this funeral d 28a Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No | Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by 4 | Homicide Certifying Physician: To the best of my knowledge, doeth conumed at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) Signature and tyle of certifie ith (Item 23a) (Type, Print) 30. Name and address of person who completed cause of de-Dakwood Ro Ste 100 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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9-	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City	Town or Lo	cation		*****			
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alti	permit. Departm Importa eny inju		21 ature of Funeral Service	Licensee	O L. D.	22.	Name and Address	ss of Facility				
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	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c								
90,	icate be executed physicien and s the burial-transit	EX	resulting in death) Last	Due to (or as	a conseque	nce of):						
68760,	cate t	edical		d							-	
	aath certifi ettending for use as		tF FEMALE; 23b. Was decedent pregnant	23c. If yes, outcome	of pregnance	cy				004	Data -4 dati	
. Box		Physician/M	in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant a	2 Fetal d	eath 3 🗌	Ectopic pregnancy Other (specify)				Date of deliv Month	ery Day Year
P.O.	by the day the tached	hys	9 Unknown	9□ Unknown								
	es the igned be del	by P	Part II. Other significant condition	_	out not result	ing in the un	derlying cause give	en in Part I.	23e. Did	tobacco use co	ontribute to t	the cause of death?
ord	w requir been si should	ted	End stage renal	disease					10	Yes 2□No	3 ☐ Proi	bably 4 Unknown
Division of Vital Records,	e law hes b	Completed					·		24a. Was	an 24	. Were auto	opsy findings available ompletion of cause of
aiF	ding Physicien: The h. h. After this certificete h. funeral director, page						_		yes Yes	ormed? 2 ☐ No	diam?	2 🗆 No
Σ	sicle: certificacto	o Be	25. Was case referred to medical examiner? 1 ∑Yes 2 □ No	Hospital:	Biller	2/0	3□ DOA Othe		ath (Check only			
of	g Physter this	<u>ان</u> ک	27. Manner of Death	28a. Date of Inju		NOutpatient 8b. Time of	28c. Injury Work	4 U Nursing F	Home 5 Resi			fy)
ion	ttendin death. ctor: Aft / the fun	ato	1 € Natural 5 ☐ Pendin 2 ☐ Accident investig	ation	y rear)	Injury		c? Yes 2 □ No				
Νį	or Atte	Certification;	3 Suicide 6 Could redeem	ined 288. Place of Inj	ury - At hom	e, farm, stre	et, factory, office		28f. Location (Street and Nui	nber or Run	al Route Number,
Ω	oital or urs efte erel Dir illed in											
	To the Hospital or Attentwithin 24 hours effer deall To the Funerel Director:	Medical	29a. Certifier 1 Certifyin (Check only one)	g Physicien: To the best Examiner: On the basis o and manner st	r examinatio	edge, death n and/or inv	occurred at the time estigation, in my op	ne, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) and date and plac	manner as s a, and due t	stated. o the cause(s)
_	ro the ro the spmple	Me	29b. Signature and tiple of certifier		ateu.		29c. License	number		29d. Date sig	ned (Month,	Day, Year)
			1/8 Vorh	and			(O.C.M.E		SEPT	. 15,	2005
h	D. HOUR		30. Name and address of person	who completed cause of d	leath (Item 2	За) (Туре, Р	rint)					
ク	1-1	1	I Whon we	Konu)			STREET,	BALTIMO	RE, MARYI	AND 21	201	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1	2005 32 Pigistr	ar's Signatur	k d	artis					
	f. legion		ا ا ا ا	2007	والر المدينان	1	3201320					

			For State Registrar	State of Maryland		artment of Health an	d Mental I	Hygiene Reg. No	61115	30382
	Physici	an	Decedent's Name (First, Middle, La	_			2. Date o	f Death Da	ay Year	3. Time of Death
7	/Medic		VANCSSA H. 4a. Facility Name (If not institution, given	BUNGER e street and number)		4b. City, Town, or Location of D	Sep		County of Death	11:00 P M
	LXamii	iei		ITAL CENTER		Westminst	er		CARRO	LL
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year If Under 24 Months Days Hours M	Hrs. 8. Date o	f Birth Day, Year	9. Birthp	lace (State or Foreign
	Director		220 38 7698 Usual Residence of Decedent	40	115.		1027	1219	17 mr	TRYLAND
	iryland show		10a. State 10b. County	10c. City,					1	0d. Inside City Limits
	the Ma	ecto	10e, Street and Number	ROLL S	> XX	SVILLE		10 0		1 ☐ Yes 2 No
	death with the Maryland ime 23a or 28a-f show rmust be notified at	ä		FORN ROAD		10f. Zip Code 2/7-84		10g. CI	itizen of What Cour	itry?
	eme 2	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of Hispanic Origin' f Yes, specify Cuban, Mexican, P	? (Specify Yes o	r No-	14. Race - Americ Black, White,	
9	filed within 72 hours after death with the Marylan Hygiene. Ither then "natural", or Iteme 23a or 28a-1 show int, the Medical Examinat must be notified at		1 Never Married 2 Married 3 Nover Married 2 Divorced	1 Tes 25 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No Specify:		·	Specify: 1 A	1
5-0036	"natura	Completed by	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupation	drin -	16b. K	(ind of Business/Ind	dustry
2	be filed within 72 hc tal Hygiene. d other then "natur event, the Madical	mpie	(Specify only highest gn Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done during most of DO NOT use retired)	working			
2	filed with Hygiene other the	CO	17. Father's Name (First, Middle, Last	0		18. Mother's	Name (First, Mid		WW Hon	16
Maryland		To Be	MITCHELL	WIDERMAN	1	10	ilia	G-0:	4:22	
a Z	2 should and Mer le marke aumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number of				
	s 1 and f Health item 27 other tr		20a. Method of Disposition	11 / wife	550 o	CANOLELIGHT sition (Name of	COVE	Sylic	Suille M	10 21784 wn, State
פֿב	9°= 5		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Special	cem	ietery, crer					
Baltimore,	permit. Pag Department Importent: any Injury o		21. Signature of Funeral Service Lice	nsee	22	. Name and Address of Facility	JN ZUM	naux	Fitted me	ivi Co.
n 	89 <u>E</u> # 8		(111)	bre	60	28 SYKOVILLE	RUAD	FIDET	SBURG-M	0 21784
			23a. Part 1. Enter the disease, or comshock, or heart failure. List only			er the mode of dying, such as care	diac or respirato	ry arrest,		Approximate Interval Between Onset and Death
}	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequer						1 week
	Examiner		Conventielly list conditions	h	ice oi).					
	sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer	nce of):				* * * * * * * * * * * * * * * * * * * *	
	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a consequer	nce of):					
04/8 19/8	death certificate be executed e attending physicien and nd for use as the burial-transit	dicai E		_ d						
٥	artifica ing ph e as th	Medi	IF FEMALE:							
gox	eath certific attending pi	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel de 4 Pregnant at time of deat	eath 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
j.	the sche	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	02	TOBIOI (Specify)				
<u>ດ</u> ກ	ss th	by P	Part II. Other significant conditions of	11		nderlying cause given in Part I.			use contribute to th	
Hecord	w require been sig should b	eted		ABRICATION	-		-	☐ Yes 2		ably 4 Unknown
Ĕ	he law e has age 2 s	Completed	MEKING ,	BRUTTA			_ a	Vas an utopsy erformed?	_ death?	sy findings available apletion of cause of
VItal		ம	25. Was case referred to medical			26. Place of I	1 ☐ Ye Death (Check on		1 Yes	2 (1) No
_	ye sic	To B	examiner? 1 Yes 2 40		VOutpatien				6 □Other (Specify)
	ding P h. After funera	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	(Month, Day Year)	Bb. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Descri	ibe how inju	ry occurred	
UIVISION	Atten	ifica	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - At home	e, farm, stre		28f. Locatio	on (Street ar Town, State	nd Number or Rural	Route Number,
5	itel or irs afte ral Dir lled in			building, etc. (Specify)						
	Hosp 24 hou Fune Fune	Medical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medicel Exer	ysician: To the best of my knowle niner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the time, date and playerstigation, in my opinion, death of	ace, and due to ccurred at the tin	the cause(s) ne, date and) and manner as sta d place, and due to	ated. the cause(s)
	To the Hospitel or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera	Me	29b. Signature and title of ceptifier			29c. License number		29d. Da	te signed (Month, L	Day, Year)
	A		I fatuel Tu	uesus		D20806		9	116/05	
	12		30. Name and address of person who	completed cause of death (Item 23	(Type,	Print) 1000 LIBERTY	ROAD	EZD	OPSBURG.	
	Sta	- 1	31. Date filed (Month, Day, Year) SEP 1 7 20	32. Pegistrar's Signature		,				
	Registr	वा		105 Janene De	60	and a				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 12:50 am Mary Duer 2005 Sept. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery 4804 Ft. Sumner Drive | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | June 11, 1931 Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 74 119-36-2414 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4804 Ft. Sumner Drive 20816 United States 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married XX Married 1 ☐ Yes 2 X No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Watercolor Landscape Artist Artistery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julia Mary deForest Beverley Duer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4804 Ft. Sumner Drive, Bethesda, MD Stanley N. Brown, Jr., husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 9/15/05 Beltsville, MD Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Rapp Funeral & Cremation Service
933 Gist Ave Silver Spring MD 20910 Rapp Funeral & Cremation S 933 Gist Ave Silver Spring

23a. Part1. Ent r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 Veare Immediate Cause (Final disease or condition resulting in death) Liver Failure years Due to (or as a consequence of): Metastic to Breast & Liver 5 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Breast Cancer Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □ Yes 2 □xNo 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🙀 No Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending XNatural investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9/14/2005 DO01768

Hospital or Attanding Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760 signed by page 2 certificate After this funeral Diractor: within 24 hours a To the Funeral

Physician

/Medical

Examiner

Funeral

Director

28e-f show

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or Itams 23a

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Item any injury or other traumatic event, Ite Medical Exerci-

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

Exemine must be notified at

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Completed

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Certification: To

Medical

death with the Manyland

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stanley Schwartz 5454 Wisconsin Ave Chevy Chase MD 20815 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2005

			1 - For State of M	aryland / Depa	artment of H	ealth and I Death	Mental Hygi	iene g. No. 20	05	30384
	Physic /Med		Decedent's Name (First, Middle, Last) Susan Edith Basham				2. Date of Death Month Septembe	Day	Year	3. Time of Death 11:45 p M
	Exami		4a. Facility Name (If not institution, give street and number) Joseph Richey Hospice		4b. City, Town, or Baltimo		1	4c. County		
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🖾 F 7. As	ge (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, SEP 23	Year) 1948	9. Birthplac Country,	e (State or Foreign) MD
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Baltimore	10c. City, Town or Lo					10d.	. Inside City Limits 1 ☐ Yes 2 🔀 No
	with the a or 28a.	Direc	10e. Street and Number 33 Holcumb Court	Dartimor	10f. Zip Code	21220	10	Og. Citizen of W	Vhat Country	?
	Maryland 21215-0036 nd 2 should be filed within 72 hours after deeth with the Maryland all hard Montal Hygiene. 27 is marked other than "natural", or items 23e or 28e-f show in traumatic event, the Markinal Examinar count be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces 1 Yes 2 Fill Yes Give Year or Dates:	No	Was Decedent of Hi. If Yes, specify Cubar 1 Yes 2 2 No		pecify Yes or No- o Rican, etc.)	14. Race	e - American k, White, etc	
	21215-0036 ad within 72 hours aff rigione. Than "natural", or than "natural" or than "natural" or	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4or	(Give	dent's Usual Occupa kind of work done d DO NOT use retired, ≥maker	furing most of wor.)	king		n Home	
	Maryland de Should be file the and Mental Hy 27 Is marked oth traumatic event	To Be (17. Father's Name (First, Middle, Last) John Ramey			Margare	ne (First, Middle, Met Doris	Lamp		
	re, Maryla s 1 and 2 should thealth and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) Brandi-Lee Basham - daught 20a. Method of Disposition	er 7008	ng Address (Street a Bank Str	ceet, Bal	Ltimore,		224	
	Page Page ment o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	C hesapeake	osition (Name of matory or other place Crenatory	Inc 9/19	9/2005	Beltsvi	1	
	Balt permit. Depart Import		21. Signature of Funeral Service Licensee	8	^{2. Name and Addres} AFA, Steph 717 Green	Pastures	Drive.	Towson.	FXTD	21286
•	Physician /Medical		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each I Immediate Cause (Final disease or condition resulting in death)	ine.	ter the mode of dying	i	1	M.	Int	pproximate terval Between pset and Death
11:45F	3760, ate be executed by sicien and mysicien and mysicien and the buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as	a consequence of): a consequence of):	enic	ciri	hosi	5	L	neurs
9/13/1		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 10 0 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delivery oth Da	y Year
_	ecords, P.Ó. Bo law requires that the death as been signed by the atter 2 should be detached for u	by	Part II. Other significant conditions contributing to death I	out not resulting in the u	inderlying cause give	en in Part I.			ibute to the d	cause of death?
ASHAM	Vital Records sician: The law requires certificate has been sign lirector, page 2 should be	Completed					24a. Was an autopsy perform	ned? d	rior to compli leath?	findings available letion of cause of
BASI	Of Phys r this aral di	To Be	25. Was case referred to medical examinar? 1 Yes 2 No Hospital: 1 Inpati 27. Manner of Death (Month, Death)			er: 4 🗆 Nursing H	th Check only one ome 5 Resider	nce 6 Dothe	er (<i>Specify</i>)	tospice
USAN	Division To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not be	jury - At home, farm, str tc. (Specify)	M 1 🗆 Y	Yes 2 □ No	28f. Location (Str. City or Town,		er or Rural R	oute Number,
502	the Hospitel hin 24 hours a the Funeral I	edical	29a. Certifier (Check only one) 1	of examination and/or in	vestigation, in my op	pinion, death occu	rred at the time, da	ite and place, a	and due to the	e cause(s)
•	To with	W	29b. Signature and title of certifier Man Quantum Community Commu	lu Mi	29c. License	32600		Od. Date signed	105	r, Year)
	31		30. Name also address of person who completed cause of the cause of the completed cause of the completed cause of the completed cause of the cause of the completed cause of the cause of the cause of the cause of the cause of the cause of the cause of t	NOIFES	7	itimo	UMP	21	287	Þ
	Regis	ate trar	SEP 1 7 2005	rar's Signature	certi					

			1 - State of Maryland / De State of Maryland / De State	epartment of Health and Modertificate of Death	1ental Hygie		30385
	=		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medic		Vernon B. Conu	10 y Jr	9 /	Day Year 4 2005	9:20 4
	Examin	er	4a. Facility Name (If not institution, give street and number)	4). City, Town, or Location of Death		4c. County of Deat	th
			1113 N. Gilmor Street	(av) If Under 1 Year If Under 24 Hrs.		N	A
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days Hours Min	8. Date of Birth (Month, Day, Ye	ear) 9. Birt	hplace (State or Foreign
			Usual Residence of Decedent		June 10,	1967	MD
	ylanc		10a. State 10b. County 10c. City, Town of	r Location			10d. Inside City Limits
	e Marine	cto	MD N/A Bal	timore			1 Pres 2 No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	ountry?
	ath w		1113 N. Gilmor Street	21217		USI	9
	er de Items	Funerai	Armed Forces?	 Was Decedent of Hispanic Origin? (Spendors) If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	rs aft	by F	1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 3 No 1 Yes 3 No 1 Yes (No 1 Yes (No 1 Yes) No 1 Yes	1 ☐ Yes 2 ☑ No Specify:		Specify: 17	lack
5-003	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or items 23e or 28e-f show ont, the Medical Examination making at		15. Decedent's Education 16a. D	ecedent's Usual Occupation	166	o. Kind of Business/	Industry
215	hin 7.	Completed	(Specify only highest grade completed) (C	Give kind of work done during most of work fe. DO NOT use retired)	ing		,
2	ad wit	Com	124	COOK		Fast	Food
p	be filed Ital Hygird of other event, I	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maid	den Sumame)	
<u>ya</u>	should ind Men marke umatic	၉	Vernon B. Conway, Sr.			Young	
Maryland	12 sho h and 7 is m ireum			tailing Address (Street and Number or Rura			
	1 and 1 Health em 27		Vernon B. Conway, Se Mather 120a. Method of Disposition 20b. Place of D	16 Shady side isposition (Name of	Road B	. Location - City or	MO 21718
altimore,	T in		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery,	crematory or other place)	0 /m =	2. Location - City of	Town, State
=	permit. Pag Department Importent: i any injury o		* 4 □ Donation 5 □ Other (Specify) AVbo	tus Mem - PK 9// 9	7705	THOUT	US MO
æ	permit. Departrimporte		1446	Har. P- Cluse	Funer	al Ser	Wee, P.A.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not	enter the mode of dying, such as cardiac of	or respiratory arrest,	Comprose 1	Approximate
5	Physician :		shock, or heart failure. List only one cause on each line.			_	Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a	losting Syn	arom	E 1	note man syss
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	and I-trans	кат	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequen	Renal Fe	1/4/	e	2415
8760,	cate be executed physician and the burial-transit		Due to (b) as a consequent (1)				•
587		edicai	d			- 1	
Box (The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	N/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	_		23d. Date of deli	verv
	death e atte d for	by Physician/M	in the past 12 months? 1 Yes 2 No. 1 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
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	res tha ilgned be del	oy P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
ord	w require been si should I	pel			1 🗆 Yes	2 No 3 □ Pro	obably 4 Unknown
Records,	has be	ple			24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
		Completed			performed	? death?	
Vita	Attending Physicien: The r death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death			
of	Physi this c	10	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa				cify)
- UC	ding Ph h. After th funeral	ion	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Tim	ry Work?	28d. Describe how it	njury occurred	
Division of	i or Attendatter deatt Director:	licat	2 Accident investigation 3 Suicide 6 Could not be determined determined		28f. Location (Street	t and Number or Co	ent Pauta Mumbas
<u>\</u>	after after Direct	Certification;	4 Homicide determined building, etc. (Specify)	street, radiory, office	City or Town, Si	tate)	rai noute ivumber,
	To the Hospitel or Attenwithin 24 hours after deall To the Funerel Director: completely filled in by the	aic	29a. Certifier 1 Certifying Physician: To the best of my knowledge, of Charle only 1 Medical Exemples (2) the best of my knowledge, of the best of my knowledge,	eath occurred at the time, date and place,	and due to the cause	e(s) and manner as	stated.
	ns Ho n 24 I ne Fu oletely	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/cand manner stated.	r investigation, in my opinion, death occurre	ed at the time, date	and place, and due	to the cause(s)
	To the l within 2 To the l	ž	29b. Signature and title of certifier	29c. License number		Date signed (Month	
,			Konnett Uni M	D 147089		9/16/	05
			30. Name and address of person who complet a cause of death (Item 23a) (Ty	pe, Print)	. 7		11. 115
			31. Date filed (Month, Day, Year) #32. Registrar's Signature	DD47079 Polling Rd #10	1/ (97	21501	ie, NID
è	Sta Registr	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 1 9 2005	who I	•		-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death CLARK Physician Month WALTER 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center Baltimore tf Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days -44-9890 2 🗆 F January 2, 1944 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or iteme 23a or 28a-f show the Medical Examiner must be notified at Ves 2 □ No **Funeral Director** 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Ne Race - American Indian, Black, White, etc. 11. Maritat Status 1€ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 2 Web þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) and Mental I hav 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) grove permit. Pages 1 end 2 to Department of Health an Important: if item 27 is eny injury or other trau 2008. 20b. Place of Disposition (Name of cemetery, crematory or other place) Oc. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Schemation 3 Removal from State 4 Donation 5 Other (Specify) Metro 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failers. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** ntracerebra /Medical Due to (or as a consequence of) Examiner io years pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine ed by the attending physicien and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown After this certificate has been signed funeral director, page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 1 Yes 2401 Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1X Natural To the Hospitel or Attending within 24 hours after death.

To the Funerel Director: After completely filled in by the fune. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Coutd not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of #15818 SEP 2,2005 M.O.

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person

Mark Louchi, M.O.

31. Date filed (North Pay Year) 2005

22.5. Greene St. Baltimore, MO, 21201

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

		Please '	Type or Print in Black I		-		
		For State	State of Maryland / Dep			_	0000:
		Registrar		ertificate of Death	La Burnet Denth	N2005	3038
Physic	ian	1. Decedent's Name (First, Middle, Las.	")	CAIN	2. Date of Death Month	8 2005	3. Time of Death
/Med		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Dea		4c. County of Death	00.34
Exami	ner		YVIEW (ARE CENTER	1 3 - 1		,	
Funera Director		5. Social Security Number 6. Se 542 -18 - 7349				'ear) Cour	place (State or Foreigntry) Regon
aryland show	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or (P	·	1	10d. Inside City Limit
8a-1	Sct	MD Balti	nore Dun	dalk	40-	Civina of Mina Co	
h with th	al Director	3430 Mc SI	have Way	10f. Zip Code 2/222	100	g. Citizen of What Cour	itry?
deat	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armer Forces?	. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Americ Black, White,	
Ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, it a Medical Examinant mat be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WW	1 ☐ Yes 2 ☑ No Specity:	nto i noan, oto.,	Specify: Wh	
215-0036 thin 72 hours af ie. an "natural", or	Completed	15. Decedent's Ed (Specify only highest grad	ucation 16a. Dec	edent's Usual Occupation re kind of work done during most of w DO NOT use retired)	orking 16	6b. Kind of Business/In	dustry
d within giene.	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	steel Worker	Z	Bethlehem	Steel
be file trat Hy od othe	Be	17. Father's Name (First, Middle, Last)	1.	18. Mother's Na	ame (First, Middle, Ma	aiden Sumame)	1
Maryland d 2 should be file th and Menta! Hy ?7 is marked oth traumatic even!	To	19a. Informant's Name/Relationship (7	VPO, Print) 19b. Ma	iling Address (Street and Number or F	45 V 1012 Rural Route Number, (City or Town, State, Zip	Code)
e, Ma 1 and 2 s Health an em 27 is other trau		Patricia Ashton		30 Mc Shave W	ay Dune	talk, MD	21222
Baltimore, Dermit. Pages 1 a Department of Her mportant: if item any injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	ematory or other place)	Date 20	oc. Location - City or To	1
Baltimor permit. Pages Department of I tmportant: If it any injury or o		* 4 □Donation 5 □ Other (Specify	GIRCLAMO	/ /	20/05 1	Baltmore	*
Balt permit. Departr tmports any info		21. Signature of Funeral Service Licen	Lela	Bradley- Ash	SDring K	eal Home d. 21222	P.A.
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death. Do not e				Approximate Interval Between Onset and Death
Physiciar /Medica		Immediate Cause (Final disease or condition resulting in death)	. CEREBROUAS	CULAR ACCI	DENT		IWEEK
Examine			Due to (or as a consequence of): ATH ERO SCLERO	OTIC CEREBRO	VASCULAR	DUENE	YEARS
1 70 H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				D.
60, be executed be executed burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. DIABETES ME	ELLITUS			YEARS
760, te be ex ysician a	<u>a</u>	l	d				
cords, P.O. Box 687 requires that the death certificate been signed by the attending phys should be deltached for use as the	Medi	IF FEMALE:	00. 1/.				
Box eath cert attendin for use	ian/	23b. Was decedent pregnant in the past 12 months?		B Ectopic pregnancy		23d. Date of delive Month	ery Day Year
tithe d	hysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknown				
S, P es that gned b	by P		ontributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the	
ord requir	ted	MEPATITIS C			1 Tes		pably 4 □Unknow
of Vital Records, P.O. Box 687 Physician: The law requires that the dealth certificate this certificate has been signed by the attending phys- rat director, page 2 should be detached for use as the	Completed by Physician/Medic				24a. Was an autopsy performe	prior to co death?	opsy findings available impletion of cause of
tal	a)	25. Was case referred to medical		26. Place of D	eath (Check only one)	No 1 ☐ Yes	2 No
Vaicie s cert	To B	examiner? 1 ☐ Yes 2 S.No	Hospital: 1 Inpatient 2 ER/Outpati	Othor		ce 6 ☐Other (Specif	かり
on of Vital Red ding Physician: The lav h. After this certificate has tuneral director, page 2		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time	of 28c. Injury at	28d. Describe how		,
Vision Attending r death. ector: After by the tune	catic	2 Accident investigation 3 Suicide 6 Could not be		M 1 ☐ Yes 2 ☐ No	004 1 1 (7)		10
- 5 P - C	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rura State)	u House Number,
pita ours herai	edical C	(Check only 2 Medical Exam	ysicien: To the best of my knowledge, de niner: On the basis of examination and/or				
To the Hos within 24 h To the Fur completely	Medi	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		d. Date signed (Month,	
To Vit	-	29b. Signature and title of certifier		23C. License Humber		sale signed (moral)	571 . 5417

SEP 1 9 2005

29b. Signature and title of certifier

29c. License number
D37089

29d. Date signed (Month, Dey, Year) 9 18 05

30. Name and address of person who completed cause of death (Item 23a) (Type Print) BATIMORE MD 21224. 31. Date filed (Month, Day, Year)

37 Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Division of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 = For State Registrar 30388 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 09 **Physician** Sara K. De Lajmanovich ŏ9 2005 03:00aM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8217 Windsor View Terrace Potomac Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 07-10-1910 6. Sex 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 95 1 □ M 2 🖾 F 218-31-4048 Director Argentina Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or itams 23a or 28e-f show troumstic event, the Medical Examinating that be notified at MD 1 ☐ Yes 2 ☑ No Director Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8217 Windsor View Terrace 20854 Argentinian s 1 and 2 should be filed within 72 hours after death 1 Health and Mental Hygiene. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 23 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1 Yes 2500 Specify: Specify: White 3℃Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) English Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Kurlat Ana Kosoy 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8217 Windsor View Terrace Potomac MD 20854 Ana Gergely other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If itel
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 09-15-2005 Beltsville MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility
Rapp Funeral & Cremation Service
933 Gist Ave Silver Spring MD 20910 M00382 Dollarice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Congestive Heart Failure Years /Medical Due to (or as a consequence of). **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter the certain Cause (Disease or injury that initiated events resulting in death) Last Years Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 1 ☐ Yes 2 No 9 ☐ Unknown 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hyerlipdenin 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Dementia 24a. Was an has autopsy performed? 1 Yes **≱**XNo Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔯 Residence 6 ☐ Other (Specify) the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. М 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a: To the Funerel D completely filled i Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year)

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year)

30. Name and

32 Aegistrar's Signature

Jose 🗷. Quiros 4343 Montgomery Ave Bethesda MD 20814

dress of erson who completed cause of death (Item 23a) (Type, Print)

D29256

09-12-2005

Registrar

	State of Maryland / Department of I State of Maryland / Department of I State of Maryland / Department of I State of Maryland / Department of I Certificate of	Health and Mental Hygiene Death Reg. NZ 005 30389
Physician	1. Decedent's Name (First, Middle, Last) DOLORES J. deWAARD	2. Date of Death Month 2. Date of Death Year Year Year Month
/Medical Examiner	Franklin Square Hospital Rose	or Location of Death 4c. County of Death Box I More
Funeral Director	5. Social Security Number 6. Sex 1 M 2EXF 77 Yrs. Asst birthday If Under 1 Year Months Days	
yiand	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. fnside City Limits
siter death with the Marklene 23a or 28a-1 einher must be nutitied	MD BALTIMORE ESSEX 10e. Street and Number 10f. Zip Code	1 ☐ Yes 2 ☒ No 10g. Citizen of What Country?
3a or		1221 USA
death of the same	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of	Hispanic Origin? (Specify Yes or No- ban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
by 18.93	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No	
DDD DDDDDDDDDDDDDDDDDDDDDDDDDDDDDDDDDD	life. DO NOT use retire	e during most of working
d 21215- d 21215- d 21215- Hygiene. ther than "nather tha	Elementary/Secondary (0-12) 12TH GRADE College (1-4or 5+) HOMEMAKER	
and 2 The filled of other covent.	17. Father's Name (First, Middle, Last) JOHN BOYER	18. Mother's Name (First, Middle, Maiden Surname) LOUELLA JOHNSTON
Maryland 2 should be it and Menial it is marked of raumatic eve		et and Number or Rural Route Number, City or Town, State, Zip Code)
re, Me	DEBORAH W. MISKIEWICZ/DAUGHTER 9603 K AMBER 20a. Method of Disposition (Name of	RLEIGH LANE PERRY HALL, MD 21128 Date 20c. Location - City or Town, State
Pages nent of the triple into	1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ace)
Baltimor Baltimor Pages Department of Important of its eny injury or o		ress of Facility THE JOHNSON FUNERAL HOME, P.A. H RAVEN BLVD. TOWSON, MD 21286
	23a. Part. Enter the disease, or complications that daysed the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line.	Onset and Death
Physician /Medical Examiner	disease or condition resulting in death) a. Vuo Co ON Due to (o) as a consequence of): Sequentially list conditions.	Archion
icate be executed physicien and stree burial-transit stree burial-transit stree burial-transit edical Examiner	That, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):	
P.O. Box 68760, nat the death certificate be end by the attending physicien letached for use as the buria. Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	cy 23d. Date of delivery Month Day Year
rds, P. (quires that the signed by Juld be detaced by Physical By	Part II. Other significant conditions contributing to death but not resulting in the underlying cause g	given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
tal Record sn: The law require infrate has been signor, page 2 should be	()	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
Vital Fricien: The rector, page	25. Was case referred to medical examiner? Hospital: Hospital:	26. Pface of Death (Check only one)
on of Vii ding Physicie h. After this cert funeral direct	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA	4 Nursing nome 5 Phesidence 6 Other (Specify)
<u>►</u>	27. Manner of Death 28a. Date of Injury 28b. Time of Injury W	ury at 28d. Describe how injury occurred ork?
rision Attendid death. ctor: A y the fu	1 Natural 5 Pending (Month, Day Year) Injury W 1 1 2 Accident sinvestigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	ork? Yes 2 No e 28f. Location (Street and Number or Rural Route Number,
Division of Vital Records, Itel or Attending Physicien: The law requires the standard death. The law than been signed by the funeral director, page 2 should be a Certification: To Be Completed by	2 Accident 3 Suicide 4 Hornicide 3 Suicide 4 Hornicide 4 Hornicide 4 See Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	ork? Yes 2 No 281. Location (Street and Number or Rural Route Number, City or Town, State)
Divisio Hospitel or Attendi 24 hours after death. Fundered Director: A lettely filled in by the tail or a filled in by the tail or a filled in by the tail or a filled in Certificati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	ork? Yes 2 No e 281. Location (Street and Number or Rural Route Number, City or Town, State) time, date and place, and due to the cause(s) and manner as stated.
Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examir	2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Licel	ork? Yes 2 No e 28f. Location (Street and Number or Rural Route Number, City or Town, State) time, date and place, and due to the cause(s) and manner as stated. y opinion, death occurred at the time, date and place, and due to the cause(s) nse number 29d. Date signed (Month, Day, Year)
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Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the th Medical Certificati	2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated. 30. Name and activess of person who completed cause of death (ftem 23a) (Type, Print)	ork? Yes 2 No e 28f. Location (Street and Number or Rural Route Number, City or Town, State) time, date and place, and due to the cause(s) and manner as stated. y opinion, death occurred at the time, date and place, and due to the cause(s) nse number 29d. Date signed (Month, Day, Year)

			1 - For State of Stat	f Maryland / D	epartment of F Certificate of			^{ene} 2005	30390	
	Dhysiair		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Yea	3. Time of Death	
	Physicia /Medic		Herbert Elmer De	nny		al and a d D and	9	14 200	5 600A M	
	Examin	er	4a. Facility Name (If not institution, give street and nur	THE WAR	4b. City, Town, o	Location of Death	0	4c. County of De	eath	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. B	irthplace (State or Foreign Country)	
	Director		217-14-9147 ^{1⊠ M 2□ F} Usual Residence of Decedent	81 Y	rs.	110013	8. Date of Birth (Month, Day, DEC 24	1923	MD	
	/land		10a. State 10b. County	10c. City, Town					10d. Inside City Limits	
	e Man	ctor	MD Baltimore	Par	rkville				1 ☐ Yes 2X No	
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If the m 27 is marked other than "natural", or tlems 23a or 28a-f show it them 27 is marked other than "natural", or tlems 2 to notified a to or other traumatic avant, the Marical Examinar must be notified.	Funeral Director	10e. Street and Number 9532 12th Avenue		10f. Zip Code 21	234	10	g. Citizen of What (USA	Country?	
	death	nera	11. Marital Status 12. Was Dece	edent Ever in U.S.	13. Was Decedent of H	lispanic Origin? (Sp	pecify Yes or No-		nerican Indian,	
0	or Ite	by Fui	Armed Fo 1 □ Never Married 2 【X Married 1 【XYes If Yes, Giv	2 □ No	1 ☐ Yes 2X No	an, Mexican, Puerto Specify:	Hican, etc.)	Black, Wi		
Ś	hour		3 ☐ Widowed 4 ☐ Divorced Year or D		Decedent's Usual Occup	pation	1	6b. Kind of Busines	white	
ה ה	hin 72 an "na Mazis	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1	-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of work	king		,	
7	filed with Hygiene. other thai	Con	8	Ma	achinist			Petroleum	l	
	d be fil ental H ked otl c avar	To Be	17. Father's Name (First, Middle, Last) John Floyd Henry	Denny			ne (First, Middle, M Marie	Wallace		
ary	and Men sand Men samerke	F	19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street				, Zip Code)	
ž,	and 2 lealth: m 27 I		Deborah Denny - wife	No. 20	32 12th Ave		2014		7	
0	Pages 1 nent of H int: If Ite iry or oti		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from	State cemetery	Disposition (Name of v, crematory or other place	ce)		0c. Location - City o		
altimor	orta inju		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Chesapea	ake Crematory 22. Name and Addre			Beltsvill -	e, MD	
Ď	Depar Impo any ir		1 S Habel	M00986	CAFA, Step 18717 Green	ss of Facility hen D. Lo Pastures	hrmann, Drive,	PA Towson, M	D 21286	
	4		23a. Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e	aused the death. Do no ach line.	ot enter the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	T. Can	cec				4 years	
	/Medical Examiner		Due to	(or as a consequence of	0.0000000				6 march	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	or as a consequence of			1.		D'ouomn	
	ecuted and transi	Examine	that initiated events	or as a consequence of	ractive Pl	Amena	MAISOG	is	4 years	
8/00,	death certificate be executed e attending physicien and of for use as the burial-transit									
20	ifficate g phys as the	ledicai	d. Lyvi	- mary					Jene	
X D D	leath certific attending p ifor use as	an/N		come of pregnancy	3 Ectopic pregnance	/		23d. Date of d	elivery Day Year	
		Physician/Me	1	ant at time of death own	5 Other (specify)			Wichin	Day	
ŗ	requires that the leen signed by the hould be detache	by Ph	Part II. Other significant conditions contributing to de	eath but not resulting in	the underlying cause giv	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?	
cords	w requires been sign should be	ed b	Advenal adonoma				1 Yes	s 2□No 3□I	Probably 4 Unknown	
ပ္	> 17 (J)	ompleted	Hypertonscon				24a. Was an autopsy	prior to	autopsy findings available completion of cause of	
<u> </u>		O	/'				perform 1 ☐ Yes 2	No 1 □ Ye	es 2 No	
VII	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes No Hospital:	Inpatient 2 ER/Out	patient 3 DOA Oth	000	th (Check only one	nce 6 ⊡Other <i>(Sp</i>	acciful	
	or Attending Physicien: after death. Diractor: After this certific in by the funeral director,	\vdash	27. Manner of Death 28a. Date	of Injury 28b. Ti		y at	28d. Describe how		outy)	
SIO	Attending or death. actor: After by the fune	catic	2 Accident investigation		M 1 🗆	Yes 2 □ No				
UIVISION	l or Attence after death Diractor: I in by the	Certification:	determined 209. Place	of Injury - At home, fari ng, etc. <i>(Specify)</i>	m, street, factory, office		City or Town,	eet and Number or I State)	Rural Route Number,	
	Hospital 14 hours a Funeral (29a. Certifier Certifying Physician: To the							
	To the Hospital or A within 24 hours after To the Funeral Dirac completely filled in by	fedical		asis of examination and ner stated.						
	To COUT	Σ	29b. Signature and title of certifier		29c. Licens	10000	•	d. Date signed (Mor	<i>←</i>	
Í	11/2		30. Name and Address of person who completed caus	se of death (Item 23a) (Type, Print)	10478		7/14/00)	
1	1, 1		AUGUSTIN CHYUMD. 370	rotech Ra	Type, Print) Ven Blvc	Belle	more 1	9D 21	2/8	
	Sta			Bgistrar's Signature	houst.					
	Registr	all	- (2003	France St	STATE					

			1 - For State Registrar	State	of Maryla	and / Dep <i>Ce</i>	artment of H	lealth and Death	Mental Hy	giene 005	30391		
			Decedent's Name (First, Middle, I						2. Date of De	ath	3. Time of Death		
	Physici /Medic		Betty Louise Dr:	iskill					Septem	Day Yeber 16, 20	05 2:00 PM		
}	Examin		4a. Facility Name (If not institution, g	imber)		4b. City, Town, or			4c. County of E	Death			
			126 Kingston Rd. 5. Social Security Number 6.	Cav	7 Ago //n :	ro loot hirth do.		River	S O Date of Dia	Balti			
	Funeral Director		235 50 2955	Sex 1 □ M 2 [[F	7. Age (in y	rs. last birthday, Yrs.	Months Days	Hours Mir	1. (Month, Da	ay, Year)	Birthplace (State or Foreign Country)		
	7		Usual Residence of Decedent					1	March I	8,1932 We	est Virginia		
	arylar show	J.	10a. State 10b. County	2200	10c.	City, Town or L					10d. Inside City Limits 1 ☐ Yes 2√2 No		
	the M	ecto	Maryland Baltime	ле		MICCI	e River			10- Chinan - 114h-			
	Sa or	Funeral Director	126 Kingston Rd.				21220	i		10g. Citizen of Wha	USA		
	death	nera	11. Marital Status	12. Was Dec	edent Ever in	n U.S. 13.	Was Decedent of H	ispanic Origin? (Specify Yes or No)- 14. Race - A	American Indian,		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23a or 28a-f show any injury or othar traumatic event, It a Madical Exemination and injury or other traumatic event, It a Madical Exemination and once.	by	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, specify Cuban, Mexican, Puèrio R 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:					into Hican, etc.)	Specify:	^{vhite, etc.} White			
2-0	72 hc	eted	15. Decedent's (Specify only highest of			(Give	dent's Usual Occupa	during most of we	orking	16b. Kind of Busine	ess/Industry		
21215-0036	d within giene. ar than "	Completed	Elementary/Secondary (0-12)		1-4or 5+)	life.	act Admin	1)		U.S. Gove	ernment		
Maryland	td be file lental Hy ked oth ic evant	To Be (17. Father's Name (First, Middle, La Chester Bolyard	st)					18. Mother's Name (First, Middle, Maiden Sumame) Virgil Glendene Reckart				
lary	2 shou and N is mar aumat	-	19a. Informant's Name/Relationship				-			er, City or Town, Sta	te, Zip Code)		
	1 and Health tam 27 othar tr		Linda Driskill (I	augnter		o. Place of Disp	ingston R		Date Date	20c. Location - City	or Town. State		
Baltimore,	Pages tment of tant: If it		1 ☐ Burial 2 反 Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec	cify)	State	ayview (matory or other plac Crematory	9/24	/2005	Baltimore	, Maryland		
Bal	permit Depar Impor any in		21. Signature of Funeral Service Lic	worker	whe	B	^{2. Name and Address} ruzdzinsk 407 Old F	i Funera	al Home I Avenue Es	P.A. ssex, Md.	21221		
Ü			23a. Part1. Enter the disease, or co spock, or heart failure. List on	mplications that of your cause on o	caused the deach line.	eath. Do not en	ter the mode of dyin	g, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ aO	cut	e Mi	10 Cano	hal	12/0	1 chi	Onset and Death		
n	Examiner			Due to	(or as a cons	sequence of):			U				
	pe tis	iner	Sequentially list conditions, any, beans to innodute cause. Enter Underlying Cause (Disease or injury	D. Quarto	(or as a none	ведиалев обл							
Ć,	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	(or as a cons	sequence of):					-			
58760,	ate be hysicia the bur	dicai	d										
-		O I	IF FEMALE:	22c If was ou	tooma of pra	20.20.21							
Box	death certifi le attending l ed for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 \(\text{ Yes} \) 2 \(\text{ No} \) 23c. If yes, outcome of pregnancy 1 \(\text{ Live birth} \) 2 \(\text{ Fetal death} \) 3 \(\text{ Ectopic pregnancy} \) 4 \(\text{ Pregnant at time of death} \) 5 \(\text{ Other (specify)} \)							23d. Date of Month	23d. Date of delivery Month Day Year		
P.O.	res that the de signed by the a be detached f	Phys	9 Unknown	9□ Unkn									
	w requires the been signer should be d	ed by	Part II. Other significant conditions	contributing to d	leath but not	resulting in the t	nderlying cause give	en in Part.			e to the cause of death? Probably 4 Unknown		
Records,	has has	Completed											
Vital	ysician: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?	4: -				26. Place of De	eath (Check only o				
of \	Physic this co	2	1 ☐ Yes 2 🔀 No			☐ ER/Outpatie		4 🗀 Nursing		dence 6 Other (5	Specify)		
Du C	ding F h. After tunera	tion:	27. Manner of Death 1 ☒Natural 5 ☐ Pending		of Injury oth, Day Year	28b. Time o Injury	Work	rat <br Yes 2 ⊡No	28d. Describe h	now injury occurred			
Division	Attending Physician: ar death. rector: After this certifica by the funeral director.	ertification:	2 Accident investigati 3 Suicide 6 Could not determine	be 28e. Place	of Injury - A	t home, farm, st	reet, factory, office	165 2 110	28f. Location (5	Street and Number or	Rural Route Number.		
Ö	rs after rs after al Dire	Certi	4 Homicide	build	ing, etc. (Spe	ecity)			City or Tow	vn, State)			
	To the Hospital or Attantwithin 24 hours after deatl To the Funaral Director: completely filled in by the	edicai	29a. Certifier 1 (Check only one) 1 Certifying F 2 Medical Exception	aminer: On the b	e best of my leasis of examiner stated.	knowledge, deat ination and/or in	h occurred at the tim vestigation, in my op	e, date and place pinion, death occ	e, and due to the surred at the time,	cause(s) and manner date and place, and o	r as stated. due to the cause(s)		
	To the within To the comp	Me	29b. Signature and title of certifier	-			29c. License	number		29d. Date signed (Me	onth, Day, Year)		
,	CIN		20 Name and address of several to	o complete d = :	no of do-45 /	tom 02=1 57	Drint)	1612	'	ey!	1-2005		
	8		30. Name and address of person whe Mohamad	AT - AC	2 R A	SHM	D 160	1 S.To1	Igati R	d. Bel A	1-2005		
	Sta	_	31. Date filed (Month, Day, Year)	005	egistrar's Sig	gnature	rack o	· · · · · · · · · · · ·	0	<u> </u>			
	Registr	CI.	V=1 1 0) L	000		15 /4	ROPE SA						

				1- State of Maryland / Dep	artment of Health and I	Mental Hyg	gien 2 0 0 5	30392
	**	Physici	> 200	1. Decedent's Name (First, Middle, Last)		2. Date of Dea		3. Time of Death
		/Medic	al	Brian Lynn Ferguso: 4a. Facility Name (If not institution, give street and number)	1 4b. City, Town, or Location of Deat		er 11, 200	5 12:12 A ^M
•	7	Examin	ier	Suburban Hospital	Bethesda	n	Montgome	
	**	Funeral Director	330	5. Social Security Number 6. Sex 1 M M 2 F 7. Age (In yrs. last birthday) 1 M Yrs.) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month Day		rthplace (State or Foreign
r 1		pue *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
9		Maryli f sho	tor	Maryland Montgomery Bethe				1 ☐ Yes 2 📉 No
2		th the	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What C	ountry?
3		ath wi	raic	7501 Democracy Blvd., #439B	20817		United Sta	
63	36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Meahal Hygiene. It files 75 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the May call Examiner must be nutified a	by Funeral	11. Marital Status 1	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- to Rican, etc.)		
3	5-003	72 hou	ted	15. Decedent's Education 16a. Dec	edent's Usual Occupation a kind of work done during most of work	rking	16b. Kind of Business	s/Industry
"	2121	s 1 and 2 should be filed within 7 if Health and Montal Hygiene. Item 27 is marked other than rother traumatic event, the Mark	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ister of Wills	King	Montgomer Governm	
Ke	and	be file tal Hy d othe	Be	17. Father's Name (First, Middle, Last)			Maiden Surname)	
67	<u> </u>	d Men marke matic	P	Albert Kenneth Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	Virle	Ileene Numbo		Zin Codo)
7	Mary	nd 2 si lith an 27 is r r traur		Albert Kenneth Ferguson/Father 18430	-		-	
axea	Saltimore,	es 1 a of Hez fitern rothe		20a Method of Disposition 20b. Place of Disp	osition (Name of	The second secon	20c. Location - City o	
2	ţi.	permit. Pages Depertment of I Important: If its any injury or o		4 □ Donation 5 □ Other (Specify) Cremator	ium, Inc. 200	5	Bethesda,	
7	Bal	Depertition of the control of the co		1100130 3	2.Name and Address of Facility obert A. Pumphrey 00 West Montgomery	Ave., Ro	ckville, M	ville, Inc.) 20850-2805
		Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	iter the mode of dying, such as cardiac ATSEST.	or respiratory arr	rest,	Approximate Interval Between Onset and Death
•		/Medical Examiner		Due to (or as a consequence of):	· Ola Lanca Chia	M 4		
		D 45	ner	Eague Itlair, institutions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury)				
2		and and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a con lac lance of):	NSI ON 2			
00	68760	ficate be executed physicien and s the burial-transit	dical E	& Smoking	abuse.			
		artificating phy	Medi	IF FEMALE:				L
50/11/6	.О. Вох	The law requires that the death certifi sie has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	Day Year
9	ds, P.	w requires that been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
2	Record	aw req s beer 2 shou	ompleted	Drug dependence.		24a. Was a		utopsy findings available
Masons	- Re	The lav	Com	Chamie obstructive polmer	y diseau,	autops perfori	med? death?	completion of cause of
3	Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		ath Check only or		
8	-	Sir di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at Work?	lome 5 ☐ Reside 28d. Describe h	ence 6 Other (Spe	ecify)
伍	ion	ending seth. or: Afte	atlo	1)SNatural 5 Pending (Month, Day Year) Injury 2 Accident investigation	M 1 Yes 2 No			
an	Division	al or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
Brlan	:	To the Hospital or Attending Pl within 24 hours after deeth. To this Funeral Director: After it completely filled in by the funeral	edical (29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, dea control on the basis of examination and/or in and manner stated.	th occurred at the time, date and place exestigation, in my opinion, death occur	, and due to the carred at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
		withir To th comp	Me	29b. Signature and table of certifier	29c. License number 1) 53691	2	29d. Date signed (Mon	th, Day, Year) 12 · 2005.
	0	27		30 Name and address of person who completed cause of death (Item 23a) (Type	Print) Blud, Be	theida,	No. 20	817.
		Sta Registr		31. Date filed (Month, Day,/Year) 32. Resistrar's Signature SEP 1 9 2005	Societé de			

			For State of	f Maryland / Department of Health and M	ental Hygiene
			State Registrar	Certificate of Death	Reg. No. 2005 30393
9.1	Physicia		1. Decedent's Name (First, Middle, Last) $D \in \Omega \subset C \cap A$ $M \neq A$	RRIS	2. Date of Death Month Day Year 1:00 PM
	/Medic Examin	44	ta. Famility Name (If not institution, give street and gu		4c. County of Death
			Lorian Nursing + Ke	hah the Baltimore	NA
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplece (State or Foreign Country) CARO I NA
4-	D		Usual Residence of Decedent	100 City Town or Location	10d. Inside City Limits
	Aarylar f show	ō	10a. State 10b. County	10c. City, Town or Location	1 Dres 2 No
	n the h	irect	10e. Street and Number	10t. Zip Code	10g. Citizen of What Country?
	ath wit	raiD	1303 n. Linwood	1 Hve. 21213	acify Yes or No-
	ter de r Items iner t	Funeral Director	Armed F	2 7 No	Rican, etc.) Black, White, etc.
903	ours a	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, G Year or I	ve 1 LIYes 2 Larno Specify:	Specify: 15/A-CK
21215-0036	oges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or Items 23s or 28e-1 show or other treumatic event, the Medical Executive Institute to notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)	ng 16b. Kind of Business/Industry
212	d with giene.	Com	Elementary/Secondary (0-12) College	1-40r5+) Nursing Assista	nt SINAI HOSPITAL
and	be filed ntal Hygi ed other event,	Be	17. Father's Name (First, Middle, Last)	\ \(\alpha = \)	e (First, Middle, Målden Surname)
Maryland	should I and Meni Is marke	ပ	19a. Informant's Name/ elationship (Type, Print)	19b. Mailing Address (Street and Number or Rura	al R _u ute Number, S _I y or Town, State, Zip Code)
	and 2		DEDORAL H. WI	111Ams 4602 Luerssen	Ave. BAHr Md, 21201
lore	Pages 1 nent of He int: If Iten iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from	comptony cromatony of other place)	Date 2 c. Location - City or Town, State
Baltimore	t. Pa rtmer rtant rjury		*4 □ Donation 5 □ Other (Specify) 21. Sign (tyle of Funeral Service Licensee	SACRE A HEART OF JESUS 22 Name and Address of Facility 7	1/20/05 Dundalk 1/4
Ba	Depa Depa Impo any ii	4	Dlorea adams	Jones 1814 N BROADWS	BAITO Md, 212X3
d	, a			caused the death. Do not enter the mode of dying, such as cardiac of activine.	or dispiratory arrest, Approximate Interval Between Onset and Death
采	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	(or as a consequence of):	(A)
16	Examiner			(or as a consequence or).	
1990	sit	iner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(or as a consequence of):	
,	te be executed ysicien and te burial-transit	Examiner	that initiated events c.	(or as a consequence of):	
3760	\$ × 8	icai	d		
89 X	death certifical e attending phy id for use as th	/Mec	IF FEMALE: 23c. If yes. o	tcome of pregnancy	23d. Date of delivery
Box	death death	ician	in the past 12 months?	birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy nant at time of death 5 ☐ Other (specify)	Month Day Year
P.0		Physician/Med	9 ☐ Unknown		23e. Did tobacco use contribute to the cause of death?
ds,	es De g	d by	Part II. Other significant conditions continuing to	leath but not resulting in the underlying cause given in Part I.	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Known
Record	aw requir s been s s should	Completed			24a. Was an autopsy findings available prior to completion of cause of
II Re		Com			performed? death? 1□ Yes 2☑ No 1□ Yes 2☑ No
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Other	n (Check only one)
of	g Phye er this eral dir	 	27. Manny of Death 28a. Date	1.50-48W.	me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
sior	Attending I rr death. ector: After by the funer	catlo	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	
Division	lor At after d Direct	Certification:	determined 200, Flat	e of Injury - At home, farm, street, factory, office ling, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospitel or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier (Check only 2 Medical Examiner: On the	e best of my knowledge, death occurred at the time, date and place, pass of examination and/or investigation, in my opinion, death occurr	and due to the cause(s) and manner as stated.
	the H hin 24 the Fi	Medical	one) and title of certifier	ner stated. 29c. License number	29d. Date signed (Month, Day, Year)
	Twill Go		▶ Am · MD	D57727	9/15/05
	6		30. Name and address of person who completed ca	se of death (Item 23a) (Type, Print)	
)		3. Date filed (Month, Day, Year) 32.	Registrat's Signature	ce buildill MDan?
912 312 312	Sta Regist		SEP 1 9 2005	Marie It Aparle	

State of Maryland / Department of Health and Mental Hygien 30394 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept. 13, Day 2005 Yeer **Physician** 9:45 PM Robertson Haskell /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Catonsville **Baltimore** If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** May 19, 1929 027-22-7103 Director Massachussetts Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 7 Is marked other than "natural", or Items 23s or 28s-f show traumatic event, the Mudical Examinar must be motified at 1 Yes 2 XNo Catonsville Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21228 14 Walden Mill Way 72 hours after death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Secretaria1 Moving and Storage 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental h es 1 and 2 should be of Health and Mental item 27 Is marked John Robertson Hazel Dodge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14 Walden Mill Way Catonsville, MD 21228 Jeffrey Haskell , Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H.
Important: If iter
any injury or oth 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Sept.16,2005 Baltimore, Maryland * 4 □ Donation 5 □ Other (Specify) Bavview Crematory 21. Signature of Funeral 22. Name and Address of Facility Brian T. Chisholm Funeral Services of MO1113 Dulaney Valley 200 E. Padonia Rd. Timonium, MD 21093 23a. Part1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onseyand Death Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): death certificate be executed Due to (or as a consequence of): burial-1 P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) lhe ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 2 this. 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of continer 29c. License number 1317 person who completed cause of death (Item 23a) (Type, Print) Greene True Pel Men Settleman 31. Date filed (Month, Day, SEP 32. Raistrar's Signature State 2005 Registrar

			1 - For State Registrar		State	of Maryla		artment of H		and M	ental Hygi	ene On C)5	30395
			Registrar 1. Decedent's Name	/Fimt Middle I	o ot)		Cei	rtificate of	Death			g. 140.	0 0	
	Physic	ian				,					2. Date of Death Month	Day	Year	3. Time of Death
	/Medi		4a. Facility Name (II	ph A.				4. 01. 7			Sept	17	05	05;15 AM
	Examir	ner	4					4b. City, Town, or			_	4c. County		,
	-		Carroll 5. Social Security N	umber 6	ty Gen	7 Age (In urs	. last birthday)	West If Under 1 Year	MINI If Under:		8. Date of Birth	Carr		lace (State or Foreign
	Funeral Director		103-32		1 3 M 2□F	62	Yrs.	Months Days	Hours	Min.	(Month, Day,		_ Coun	itrv)
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	nyian how	١.	10a. State	10b. County		10c. C	ity, Town or Lo	cation					1	0d. Inside City Limits
	e Ma	cto	MD	Baltir	nure		G	wynn c	Jak					1 ☐ Yes 2 No
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	ath w 23e	Funeral Director	3332	North	nont	RCL	_	2124	14			u.s	S.A.	
	ltems	nue	11. Marital Status	3 .:	Armed F		J.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Orig	gin? (Spe	cify Yes or No- lican, etc.)	14. Rad	ce - Americ	an Indian, etc
36	s afte	by F	1 ☐ Never Marrie 3 ☐ Widowed		If Yes, G		1	1 ☐ Yes 2 No	Specify:				Bla	
21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other then "neturel", or Items 23e or 28e-f ehow event. The Medical Examinar must be reditted at	ed t	3 🗆 11.001160	15. Decedent's	Year or I	Jates:	162 Door	dent's Usual Occup	ation				21	
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Maryland	d 2 should th and Mer 7 le marke treumatic	-	19a. Informant's Na				19b. Mailin	g Address (Street a	and Numbe	r or Rural	Route Number,	City or Town,	State, Zip	Code)
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re	of Healt fitem 2		20a. Method of Disp	osition		20b.	Place of Dispo	sition (Name of natory or other plac			1 77	c. Location -		
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Baltimore,	permit. Page Department of Importent: If eny injury or once.		21. Signature of Fur	neral Service Lic	ensee	·	22	. Name and Addres	e of Eacilib	1				
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			23a. Part1. Enter the shock, or hear	e disease, or contract	nplications that	caused the dea	th. Do not ente	er the mode of dying	g, such as o	cardiac or	respiratory arres	t,		Approximate Interval Between
	Physician		Immediate Cause (I	Final		Mota	2 tatic	Bladd	tr (Car	Code u on 2			Onset and Death
	/Medical Examiner		resulting in death)	-	Due to	(or as a consec		1-1-						-
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587	ficate phys s the	dical			d									
		/Me	IF FEMALE: 23b. Was decedent	program	23c. If yes, ou	tcome of pregn	ancy					22d Day	to of deliver	
Вох	death certi e attending id for use a	Physiclan/M	in the past 12 r	months?	1 Live t	oirth 2 ☐ Feta nant at time of d	al death 3 🗌	Ectopic pregnancy Other (specify)				Mo	te of deliver nth	Day Year
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	law requires that the de as been signed by the a 2 should be detached f	by PI	Part II. Other signifi	cant conditions	contributing to d	eath but not res	sulting in the un	iderlying cause give	n in Part I.		23e. Did toba	cco use cont	ribute to the	e cause of death?
rds	w require been sig should b			ulmonum							1 ☐ Yes	2 🗆 No	3 🗆 Proba	ibly 4 Únknown
00	aw re	olet	P	rubabl	e 50	wel	06142	netion			24a. Was an	24b. \	Nere autop	sy findings available
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of Vital Records,		0	25. Was case referre	ed to medical					26 Place	of Death	1 ☐ Yes 2 ☐ Check only one)	≤ No 1	Yes 2	2LI No
Ž	Phyeicl this cer al direc	To B	examiner? 1 ☐ Yes 2	No	Hospital: 1	Inpatient 2	ER/Outpatient	3□ DOA Othe			e 5 Residence	xe 6 □Oth	er (Specify)	
0	ng PI ter th		27. Manner of Death		28a. Date		28b. Time of Injury	28c. Injury Work	at 2	28	d. Describe how	injury occurr	ed	
<u>Ö</u>	andir ath. or: Af	atlo	2 Accident	5 Pending investigation	n	,,	ii ijai y		es 2□N	lo				
Division	r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determined	286. Place	of Injury - At h	ome, farm, stre	et, factory, office		28	f. Location (Stree City or Town, 5	et and Numb	er or Rural	Route Number,
	rs aff	Cer			<u> </u>	3, 1,7					0.9 0. 70, 0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	To the Hospitel or Attending Physiclen: which 24 hours after death and the funerel Director. After this certific completely filled in by the funeral director,	Medical	CHECK UNITY	1 Certifying P 2 Medical Exe	miner: On the b	asis of examina	owledge, death	occurred at the tim estigation, in my op	e, date and	place, an	d due to the caus	e(s) and ma	nner as sta	ited,
	the l	Med			and man	ner stated.								
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1	n, d		30. Name and addre			se of death (Item	n 23a) (Type, F	rint) ten St.	110	+4	item !	41 2	1157	>
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	Sta Registr	_	S. Date filed (Moliti	EP 1 9 2	005	gištrar's Signa	H. A	nelle 1						
				- 0		andrea.	19							

			1 - For State Registrar	State of Maryla	nd / Depa	artmen rtificate	t of Health e of Death	and Menta	al Hygien	2005	30396
1	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Last) WALTER M 4a. Facility Name (If not institution, give some state) 13801 York Road	IERRYMAN HAL		4b. City,	Town, or Location	2. Da M Sej	onth Death Dotember	14, 2005	3. Time of Death 8:20AM M
- A 188	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yr.	s. last birthday) Yrs.			or 24 Hrs. 8. Da Min. Janu	ite of Birth onth, Day, Yea ary 1, 19	9. Birth O26 Mary	Place (State or Foreign ntry) Land
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "natural", or items 23a or 28s-f ahow appringuty or other traumatic event, I'm Medical Evarulian missi is inclified at ADGE.	Il Director	10a. State 10b. County Maryland Baltimore 10e. Street and Number 13801 York Road		Ckeysvi		Code 2103	30	10g. C	Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☐ No ntry?
9003	hours after deati tural', or itema 2	Completed by Funeral Directo	1 ☐ Never Married	12. Was Decedent Ever in Armed Forces? XX Yes 2 □ No WW If Yes, Give year or Dates:	II	1□Yes X					ite
Baltimore, Maryland 21215-0036	filed within 72 I Hygiene. other than "nat	Be Complete	15. Decedent's Edur (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)		(Give	kind of woi DO NOT us	Estate	est of working		Kind of Business/fr Banking on Sumame)	dustry
rylan	hould be d Mental marked matic ev	To B	Robert William Hal 19a. Informant's Name/Relationship (Ty)		10h Mailie	. Addana		Eleanor		in or Town, State, Zip	
e, Ma	and 2 s lealth an m 27 le her traus		Frances Baker Hale	Wife	13801	York	Road Co	ckeysvi	lle, Mai	ryland 21	030
more	Pages 1 nent of H int: if ite try or ot		20a. Method of Disposition 1 ☐ Burial X Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Place of Dispo cemetery, cren eenMoun	natory or of	her place)	9/15/05		Location - City or To timore, M	
Balti	permit. Departn Imports any inju		21 Signature of Funers License	len Kenser	Cos		65	500 York Ro	o <mark>a</mark> d Balti	eld Funeral more, Maryl	
) % ,	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Acute C Due to (or as a conse	oronary			s cardiac or respi	ratory arrest,		Approximate Interval Between Onset and Death
8760,	rate be executed by sician and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to numericate cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse							
P.O. Box 68	Attending Physician: The law requires that the death certificate be executed crossin. Grown After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregi 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	al déath 3	Ectopic pre				23d. Date of delive Month	ery Day Year
	uires that n signed b ld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobac Atrial Fibrillation, ASCVD, Diabetes Mellitus								ne cause of death?
tal Recol	ysician: The law require Is certificate has been sid director, page 2 should b	e Completed	25. Was case referred to medical					1	a. Was an autopsy performed? Yes 2XXV	prior to co	psy findings available mpletion of cause of
Division of Vital Records,	inding Physicis ath. ir: After this cert ie funeral direct	To B	evaminer?	ospital: 1 Inpatient 2 [28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		0.0	ursing Home 🕏	(Check only one) a XX Residence 6 Other (Specify) 3d. Describe how injury occurred		
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	To the Hospital within 24 hours a To the Funeral I completely filled	Medicai	29a. Certifier (Check only one) 2 Medical Examin	icien: To the bast of my kn ter: On the basis of examin and manner stated.	ation and/or inv	estigation,	t the time, date as in my opinion, dea	nd place, and de- ath occurred at th	to the cause(s e time, date an	d place, and due to	ated. the cause(s)
)	To the To the comp	Me	29b. Signature and little of certifier	and I	<i>></i>	29c.	License number D22627		29d. Da	ate signed (Month, September	Day, Year) 14, 2005
10	21		30. N and address of person to coor Francis Sanzaro MD		Road Co	ckeys	ville, M	aryland	21030		
	Sta Registr		31. Date filed (Month, Day, Year) 2005		ature #	ون					

State of Maryland / Department of Health and Mental Hygien 2005 30397 1 - For Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September lo, **Physician** Florence P. Hipkins 2005 23:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Pebruary 14, 1931 Sebruary 14, 1931 Washington D.C. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 1 F Yrs. Director 578-40-3608 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "natural", or iteme 23a or 286-f show troumstic event, the Madical Examinar must be notified at 1 Yes 2 □ No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1996 Milboro Drive 20854 United States death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iten any njury or other treumatic event, the Medical Example 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Patent Copying Business Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Isabel Kenworthy Richard Philpitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Hipkins/ Son 1996 Milboro Drive, Rockville, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State September Cedar Hill Cemetery Suitland, Maryland 16, 2005 4 Donation 5 Other (Specify) 22. Name and Address of Facilit Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Lice yee M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) minules sudden Cardiac death /Medical Due to (or as a consequence of): Examiner WINGS consestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or s a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): the attending physicien Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ρģ Month Year Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been si rector, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Teath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending hours after death. unerel Director: A М 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funerel D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai npletely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M. Smith MD 559129 09/13/2005 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aaron Snyder, M.D. 9901 Medical Center Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 9 2005

			1 - For State Registrar	State of M		Department of Certificate of			ene 200	5 30398			
	Physici		Decedent's Name (First, Middle,	Grace E	. Henry			2. Date of Death Month	Day Ye	ar 3:35 PM M			
	/Medic Examir		4a. Facility Name (If not institution,			4b. City, Town	, or Location of De		4c. County of E				
				ional Hosp			Laurel		Prin	ce George's			
п	Funeral			. Sex 7. A 1 □ M 2 💢 F	ge (In yrs. last bir	thday) If Under 1 Year Yrs. Months Day		n. (Month, Day,	Year) 9.	Birthplece (State or Foreign Country)			
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	yland		10a. State 10b. County		10c. City, Town	n or Location				10d. Inside City Limits			
	Se-f s	ctor	Maryland Princ	e George's		S	ilver Spi	ring		1 ☐ Yes 2 🎇 No			
	or 28	Director	10e. Street and Number			10f. Zip Code			g. Citizen of What	Country?			
	s 23a		3142 Graces				20904			ed States			
· ^	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 Is marked other than "neturel", or Items 23a or 28e-1 show other treumatic event, the Madical Executations and the natified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Deceden Armed Forces 1 ☐ Yes 2 🕅	?	13. Was Decedent of If Yes, specify Co	f Hispanic Origin? (Jban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)		merican Indian, hite, etc.			
21215-0036	ral', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 X N	o Specify:		Specify:	White			
2 2	72 hc	Completed	15. Decedent's (Specify only highest of	Education grade completed)	16a.	Decedent's Usual Occ (Give kind of work dor		odkina 1	6b. Kind of Busine				
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au	id be ental ked o	To Be		l Irwin Hei	nemann		To: Mother's 14			l- a			
Maryland	should ind Men s marke umatic	۲	19a. Informant's Name/Relationship			Mailing Address (Stre	et and Number or	Grace Le					
	is 1 and 2 of Health a item 27 ls other tree		James J. Henry	/ Husband						ary1and 20904			
altimore,	of He of He of It item		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3	□ Removal from State	20b. Place of	Disposition (Name of y, crematory or other p		Date 2	Oc. Location - City				
Ē	. Pag tment tant:		`4 ☐ Donation 5 ☐ Other (Spe	cify)	Crem	iatorium In	C. ! I	tember 3, 2005	Bethesd	a, Maryland			
Ba	permit. Pages 1 Department of H Important: If ite any injury or ott		21. Signature of Fund al Service Lic	Lest	M00335	22. Name and Add Rockvil Rockvil	ress of Facility Rolle, Inc. le, Maryl	bert A. P 300 West Land 20850	umphrey Montgome -2805	Funeral Home/ ry Avenue			
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	inplications that cause by one cause on each	d the death. Do n	ot enter the mode of d	ying, such as cardia	ac or respiratory arres	st,	Approximate Interval Between			
	Friysician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition product of the condition at the cause of the										
	/Medical Examiner	resulting in death) Oue to (or as a consequence of):											
	*	ē	Sequentially list conditions, if any, leading to immediate		intestio	nal Bleedi	ng			1 Week			
	uted d ansit	Examiner	Cause (Disease or injury that initiated events		Failure					1 Week			
o,	be executed sician and burial-transit		resulting in death) Last		a consequence of	of):				1 Week			
8760	cate be executed physician and : the burial-transit	dlcal		d									
9		0	IF FEMALE:	23c. If yes, outcome	of pregnancy								
Box	death certifi e attending d for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death	3 ☐Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date of o Month	delivery Day Year			
o.	at the de by the a tached	hysi	1 ☐ Yes 2 🕅 No 9 ☐ Unknown	9□ Unknown		- Carlot (Speciny)							
S, T	as the	by P	Part II. Other significant conditions	contributing to death t	ut not resulting in	the underlying cause of	iven in Part I.	23e. Did toba	cco use contribute	to the cause of death?			
ecords,	w require been sig							1 ☐ Yes	2 X No 3□	Probably 4 Unknown			
ပို	e lawr has be ge 2 sh	Completed						24a. Was an autopsy	24b. Were	autopsy findings available o completion of cause of			
<u>~</u>		Co						performe	ed? death	? es 2□ No			
Vital	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital:			thor	ath (Check only one)		1			
	his his	⊢ ,,,	1 ☐ Yes 2 X No 27. Manner of Death	28a. Date of Inju	ry 28b. Ti	patient 3 DOA	4 Nursing I	Home 5 Residen		pecify)			
lo O	Attending I r death. ector: After by the funer	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Da on	y Year) In	jury W	ork?]Yes 2.∏No		.,.,				
UIVISION	I or Atten after deatl Director: I in by the	ertification;	3 ☐ Suicide 6 ☐ Could not determine	d 28e. Place of In	ury - At home, far c. (Specify)	m, street, factory, office		28f. Location (Stre City or Town,	et and Number or	Rural Route Number,			
2	urs after	O											
	he Hospitel or in 24 hours afte the Funerel Dir pletely filled in	edical	29a. Certifier 1 ☐ Certifying F (Check only one) 2 ☐ Medical Ex-	Physician: To the best aminer: On the basis of and manner st	r examination and	death occurred at the Vor investigation, in my	time, date and plac opinion, death occ	e, and due to the cau urred at the time, date	se(s) and manner a and place, and d	as stated. ue to the cause(s)			
	To the h within 2. To the I	Σ	29b. Signature and title of certifier	Ruthur		29c. Licer	se number	290	. Date signed (Mo	nth, Day, Year)			
	0		Moviem				D59524	9	September	12, 2005			
1	2		30. Name and address of person who			,	רנת נפפס	77.00 Cm	- M	1 20004			
	Stat	e	Loveen J. Puthu 31. Date filed (Month, Day, Year)	ımana, M.D. 32. R∰gistr	ar's Signature	racefield	road, 511	ver sprin	g, maryla	111G ZU9U4			
	Registra		SEP 1.9	32. Registr	ARS SS.	grace							

				For State Registrar		State of	of Maryla	nd / Dep	artmei	nt of H	ealth and l Death	Mental Hy			303	99
				Decedent's Name	(First, Middle, La	ast)					,	2. Date of D	Reg. No eath		3. Time o	f Death
_		Physici /Medic				He	rbert	A. Joh	nson			Seale	embe			25AM
		Examir		4a. Facility Name (If	not institution, gi			4.		, Town, or	Location of Deatl			. County of De	-	
				Genes	5 Eld.	ercare	ate	in Man		Balto				N/A		
		Funeral		5. Social Security Nu		Sex 1∭XM 2□F		s. last birthday) If Under Months	Pr 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	rth ay, Year,	9. Bi	rthplace (State country) Md	or Foreign
		Director		212-30-06 Usual Residence of I	68		74	Yrs.				8-6-	1931		Ma	
		land ow		10a. State	10b. County		10c. 0	City, Town or L	ocation						10d. Inside C	ity Limits
		Mary -f sh	to	Md	N/A			Balto							1 X Yes	2 🗆 No
		death with the Maryland ms 23a or 28a-f show r niust be notified at	irec	10e. Street and Num	ber				10f. Zi	ip Code			10g. Ci	tizen of What C	country?	
		th wit	a D	3910 Edm	ondson .	Avenue				2	21229		U	S A		
		ems erms	Funeral Director	11. Marital Status		12. Was Dec	edent Ever in orces?	U.S. 13.	Was Dece	edent of His	spanic Origin? (S n, Mexican, Puert	pecify Yes or N		14. Race - Am Black, Wh		
)	36	s afte	by Fu	1 Never Marrie		1 ☐ Yes If Yes, G	ve -		1 ☐ Yes		Specify:	,			Black	
8	Ö	hour turel		3 Widowed 4	15. Decedent's E	Year or E	Dates:	16a Door	dont's Hay	Inl Conum	tion		105 1			
5	15	in 72 n "na	olet	(Specif	fy only highest gr	rade completed)		(Give	kind of w	ork done d use retired)	tion uring most of wor	rking		(ind of Busines:		4 - 7
drivor	21215-0036	y with	Completed	Elementary/Secon		College (N/A		Janit					kosewoo	d Hospi	tai
1	b	e filed al Hyg othe vent,	Bec	17. Father's Name (F	First, Middle, Las	t)					18. Mother's Nan	ne (First, Middle	, Maider	Sumame)		
+	/lai	uld b Ments rrked	To	Thomas H	l. Johns	on					Mary F	iggs				
terbest	Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "naturel", or Items 23s or 28a-f show may injury or other treumetic event, the Mudical Examination usit or multified at once.		19a. Informant's Nar Mildred			.				nd Number or Ru			or Town, State,	Zip Code)	
9	e,	1 and Health sm 27 ther t		20a. Method of Dispo		- Daugiii		. Place of Disp			e Balto	, Md 212 Date		annian City	Town Otata	
土	סַ	ages nt of the		1 X Burial 2 □	Cremation 3		State	cemetery, cre	matory or	other place	·			ocation - City o		
	語	it. Partment		° 4 ☐ Donation :			1 3	t Luke				4-2005		isterst	own, Md	
	Ba	permil Depar Impor eny ir		10	Jume .	1	um PR				labash A	March F		West	1215	
				23a. Part 1. Enter the	e disease, or con	nplications that	caused the de							3, 11d 2	Approximat	te
		Physician		Immediate Cause (F	t failure. List only Final			F. 12.11.							Interval Bet Onset and	
		/Medical		disease or condition resulting in death)	-	a	(or as a conse	equence of):	<u>, </u>							
		Examiner		Sequentially list con-	ditions	b. Me	. Hos hetic	Rech	/ Colo	n Gun	امهان					
		P +=	iner	Sequentially list con- if any, leading to im- cause. Enter Underl Cause (Disease or in that initiated events	nediate lying	Due to	(or as a conse	equence of):	-							
		ecute and -trans	Examiner	that initiated events resulting in death) La	ast	C. Dua to	(or as a conse	augan of).								
	8760,	cate be executed physicien and the burial-transit				Duo to	(or as a conse	squerice or).								
	587		edical		•	d										
	Box (w requires that the death certifi been signed by the attending should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, ou								23d. Date of de	livery	
	B.	death e atte	iciai	in the past 12 m	nonths?	4□Pregr	oirth 2 🗆 Fe nant at time of		□Ectopic p □ Other (s					Month		Year
	P.O.	at the by th tache	hys	9 🗆 Unknown		9□ Unkn	own									
		es tha	by F	Part II. Other signific			eath but not re	asulting in the u	ındərlying	cause givei	n in Part I.				o the cause of o	leath?
	ord	w requir been si should		U1	rosepsis	HTW						1 🗆	Yes 2	□No 3□P	robably 4 🖃	Inknown
	ec	× 0 2	Completed									24a. Was		24b. Were a	utopsy findings completion of c	available ause of
	<u>=</u>	The cate h	Sol									perfo 1 ☐ Yes	rmed?_	death?	2 □ No	
	Vita	sicien; The lav certificate has irector, page 2	Be	25. Was case referre examiner?	_	Hospital:					26. Place of Dea					
	of	Phys this al di	To:	1 Yes 2 7	lo .	1 10		ER/Outpatie			4 Nursing H	ome 5 Resi			cify)	
	no	ding F h. After funeri	tlon	1 Natural	5 Pending		of Injury th, Day Year)	28b. Time o Injury	M	28c. Injury Work¹	at ? es 2 □ No	28d. Describe	now inju	ry occurred		
	Division of Vital Records,	Atten deat ctor: y the	fica	2 Accident 3 Suicide	6 Could not be determined	28e. Place	of Injury - At	home, farm, st			00 2010	28f. Location (Street ar	nd Number or R	ural Route Num	ber.
	<u>S</u>	after after Dire	Certification:	4 Homicide	determine	build	ing, etc. (Spec	cify)		,,		City or To	wn, State)		,
		ospite hours unere ly fille		29a. Certifier	Certifying P	hysician: To the	best of my kr	nowledge, deat	h occurred	at the time	e, date and place,	, and due to the	cause(s)	and manner as	s stated.	
		To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	ledical	one)	2 Medical Exa	miner: On the b	asis of examir ner stated.	iation and/or in	ivestigation	n, in my opi	nion, death occur	rred at the time,	date and	place, and due	to the cause(s)
		To To	Ž	29b. Signature and ti	itle of certifier				1	c. License			29d. Dat	te signed (Mont	h, Day, Year)	
	7	7			Mark					100	62634	t	7/1	3/17		
	-	2		MATERN HWA		IHAMM.		FRRY R	Print)	BAL	62634 TIMME	MA	212:	, –		
		Sta		31. Date filed (Month	, Day, Year)		legistrar's Sigr	nature &	20	7-1-	1	-10	-12			
		Registr		SE	P = 1920	05 33	Sugar L	7 Sept	A Carl							

State of Maryland / Department of Health and Mental Hygien 205 30400 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Gordon Charles Keiser 1^{Da} 2005 Sept 9:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Continuum Care Sykesville Carroll 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**⊠** M 2□ F 81 Director 218-18-9806 Aug 23/1924 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 No MD CArroll Westmisnter 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1155 Canon Way iteme 23a 21157 United States Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Iteme 23 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 Yes 2X No Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Meat Packer Eskay 8th other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roland Keiser Myrtle Fifer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eep rtment of Health a In portant: If item 27 is a y injury or other tree or 3. 1155 Canon Way Westminster, MD 21157
Date of Disposition (Name of Dispos Ruth Keiser (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1- Burial 2 Cremation 3 □Removal from State Carroll Crematory 9/16/2005 Winfield, MD ` 4 Donation 5 Dother (Specify) parrent. 21. Signature of Foreral Service gicensee 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Winfield pro MD Immediate Cause (Final Physician 16517 101100 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 1000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit or Attending Physicien: The law requires that the death certificate be executed 10700 physician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 donknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Dursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ NO Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funerai 27 Manner 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 atural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours at To the Funerel Di 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 01 death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Rate Special Const

			For State Registrar	State of M	arylan	d / Depa <i>Cei</i>	artment <i>tificate</i>	of H	ealth a	and M	ental Hy	giene Reg. No.	005	30401
	Physici /Medic		1. Decedent's Name (First, Middle, Las) Le							2. Date of De	aath Day		
	Examir		4a. Facility Name (If not institution, give Shady Grove Adven		ital			own, or	Location o	of Death	9		County of De	ath
	Funeral Director		Social Security Number 6. S			ast birthday) Yrs.	If Under		If Under : Hours	Min.	8. Date of Bir (Month, Da Iarch 22	ay, Year)	9. B	irthplace (State or Foreign Country) W York
	e Maryland la-f show	ctor	10a. State 10b. County Maryland Montgo	mery		, Town or Lo German								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 28 Int be no	Funeral Directo	10e. Street and Number 19609 Crystal Rock	Drive #1			10f. Zip (Code 374					zen of What (·
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or Itams 23s or 28s-1 show or other traumatic event, the Modical Examinar must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 250 If If Yes, Give Year or Dates:		- 1		ent of His fy Cubar	spanic Orig n, Mexican Specify:	gin? (Spec , Puerto P	ify Yes or No			nerican Indian, lite, etc.
Maryland 21215-0036	within 72 ho iene. r than "natu	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	ucation le completed) College (1-4or 5	i+)	lite. L	lent's Usual kind of work DO NOT use abore	done d retired)	uring most	of workin	g		nd of Busines	
yland 2	12 should be filed and Mental Hygin I smarked other raumatic event, II	To Be C	17. Father's Name (First, Middle, Last) James Annand Luke				abore				(First, Middle)			LION
e, Man	1 and 2 sho Health and am 27 is mu ther trauma		19a. Informant's Name/Relationship (T) Gregory A. Luke/So 20a. Method of Disposition	,	20b PI		Shak	espe			, Germ	anto	Town, State, Wn, MD cation - City o	20876
Baltimore,	t. Partmer		1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Licens		Mon	metery, crem tgomer Cremat	natory or oth Y Orium	ne <i>r pla</i> ce	6	epter 19	mber 2005	Beth	esda. N	Maryland
B B	permi Depa Impo any in		23a. Part1. Enter the disease, or comp	lications that caused	1386 the death	KU	CKVII.	re,	maryl	Land	<u> </u>	2805	omery	uneral Home/ Avenue
	Pnysician /Medical Examiner		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Out to or as	My	ocará								Interval Between Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as										
68760,	ficate be executed physician and is the burial-transit	edicai E		Due to (or as	a consequ	ence or):								
.O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic preg Other (spec					2	3d. Date of de Month	slivery Day Year
٥.	w requires that been signed b should be deta		Part II. Other significant conditions co	ntributing to death bu	ut not resul	lting in the un	derlying cau	ıse givei	n in Part I.			obacco us		o the cause of death?
Vital Records,		Completed									24a. Was autop perio 1 🗆 Yes	sv	24b. Were a prior to death?	utopsy findings available completion of cause of
									☐Other (Spe	əcify)				
Division of	Attending Pher death. ractor: After the	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 28b. Time of Injury M 28b. Time of Injury M 28b. Time of Injury M 28b. Time of Injury M 27. Manner of Death 1 North 1 No								28 lo	d. Describe h	ow injury	occurred	
D.	Hospital or Atteno 24 hours after death Funeral Diractor: tely filled in by the		4 Homicide determined	28e. Place of Inju- building, etc	(Specify)						City or Tow	m, State)		ural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Diractor: After completely filled in by the fune.	Medicai	(Check only one) 20 Medical Exami	sician: To the best of ner: On the basis of and manner sta	examination	on and/or invi	estigation, ir	n my opi	nion, death	place, an occurred	at the time, o	date and	and manner as place, and due signed (Moni	e to the cause(s)
	es ((Olles Shine	lens			DE	369	79		3	Sente	mlen	13, 200x
	10		30. Name and address of person who co	II no	1901	me	rint) dical	C	ente		n B	od	will	13, 200x
	Sta Registr	-	31. Date filed (Month, Day, Year) SEP 1 9 2	32. Registra	s signatu	de A	sector							

State of Maryland / Department of Health and Mental Hygiene 30402 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Dorothy I. Myers 10:30 AM September 14,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Middle River 20 Chandelle Rd. Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 24, 1919 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 □ YE 212 28 8776 86 England Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f ahow 1 ☐ Yes 2 No Maryland Baltimore Middle River Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 Chandelle Rd. 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Specify: White Maryland 21215-0036 "natural", or 1 Yes 2X No Specify: ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Payroll Clerk Aerospace 12 and Mental Hygi 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be tilt Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other traumatic avant 20xe. Be Robert Turner Gertrude Goodrum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norvelle Moore (Personal Rep.) 15 Chandelle Rd. Baltimore, Maryland 21220 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Holly Hill Mem. Garden's 9/16/2005 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 21. Sign Aure (i) Funeral Service Ligenses 1407 Old Eastern Avenue Essex, Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ve Kulmona **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760 the attending physician Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day detached for 5 Other (specify) 1 ☐ Yes 2 🔯 No 9 Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, å 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? EC 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√2 No Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient in by the tuneral 28c. Injury at Work? 28b. Time of 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 X Natural 5 Pending 1 Tes 2 No death. investigation To the Hospital or Attendi within 24 hours after death To the Funeraf Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Fype, Print) 9101 Franklin Square Dr. Suite# 205 Baltimore, Maryland 21237 Joyce E. King, M.D. 31. Date filed (Month, Sax, Year) 32. Registrar's Signature State Registrar

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				1 - State Registrar		Cei	tificate of	Death		g. No. U U	0	30403
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	y.	/Medi Examir		4a. Facility Name (If not institution, give	street and number) -			or Location of Death	Sept	4c. County of		10:25 A M
		LAGITIII	8	Gilcheist	Hospice			WSON				more
		Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth	9		ace (State or Foreign
	-	Director		21101011	M 2UF	5 4 Yrs.		110010		1851		ew YORK
		•how		Usual Residence of Decedent 10a. State 10b. County	100	: City, Town or Lo	çation				10	Od. Inside City Limits
		Mary a-f eh	tor	MARYLAND	B	Altim	ore					Yes 2 □ No
		th the Market or 28a-f	lrec	10e. Street and Number		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10f. Zip Code		10	g. Citizen of Wh	at Count	ry?
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		urs after death with the Maryla al', or Itema 23a or 28a-f eho Examinat must be notified at	by Funeral Director		12. Was Decedent Ever Armed Forces?	in U.S. 13. 1	Was Decedent of I Yes, specify Cub	Hispanic Origin? (Spenan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black,	America White, e	
	36	irs aft	by F	1 Never Married 2 Married 3 Widowed	1 Tes 2 No If Yes, Give Year or Dates:		☐ Yes 2 📉 No	Specify:		Specify:	11	16. Le
	21215-0036	72 hours after death with the Maryland natural", or Itema 23a or 28a-f ehow aleat Examinat must be notified at	ted	15. Decedent's Edu	cation	16a. Deced	lent's Usual Occup	pation	1	6b. Kind of Busin	ness/Ind	ustry
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		T1 70 - 11		11+1		T	euck	DRIVER				MALL
	and	\$ \$ \$ \$ \$	Be	17. Father's Name (First, Middle, Last)	^	1:1		18. Mother's Name	(First, Middle, M	1/	_	
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A	Je,	es 1 and of Health filtem 27 r other tr		20a. Method of Disposition		b. Place of Dispo	sition (Name of patory or other pla		ate 2	Oc. Location - Cit	y or Tov	vn, State
3	Ē	Pages Iment of I tant; If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Preenmou		'	19 05	BAltu	Lo of the	MARKEM
	Baltimore,	permit. Pag Department Important; I eny injury o		21. Signature of Funeral Service License		22	Name and Addre	ess of Facility	101/010			KAR HOME
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MIL	E B	yeicien: The is certificete ha	Completed						autopsy performe	ed? deat	h? Yes 2	
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	of	ਦ ≑ ख	<u>P</u>	1 Yes 2 No	1 ☐ Inpatient 2 28a. Date of Injury	ER/Outpatient	3□ DOA Dth	4 Inursing Hon	ne 5 Residen		Specify)	tospico
	O	ting After	tlon	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year	28b. Time of Injury	28c. Injun Worl	yat k? Yes 2 □No	8d. Describe how	injury occurred		/
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	ā	s afte	Certification:	4 Homicide determined	building, etc. (Sp	ecify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,	State)		iosio i isinooi,
		To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier (Check only 2 Medical Examin	cian: To the best of my er: On the basis of exam and manner stated.	knowledge, death	occurred at the tin	ne, date and place, a	nd due to the cau	se(s) and manne	r as stat	ed.
		the hin 24	Medical		and manner stated.	milation and/or my						
		vitt To		29b. Signature and title of certifier	0.0		29c. License			I. Date signed (M		
		,		30. Name and address of person who con	profeed cause of death (Som 222) (7	00	7 207	7	yen	ver	16,2001
		4		W. A. Rile		6 70 / W	Char	les ST. 1	Sulto. 1	nd 21	20	.16, 2005- k
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			1- State Unpend Item 23a,27,	28a-f per me	G847 9 25 65 Cas w	Ben	2005	30404
	Dhusisi		Decedent's Name (First, Middle, Last)			2. Date of Death Month		3. Time of Death
	Physici /Medi		CHRISTOPHER CLA				$\mathbb{R}^{15}, 2005$	2:56P. M
	Examir	ner	4a. Facility Name (If not institution, give street and no	umber)	4b. City, Town, or Location of Death		4c. County of Death	
			594 PUMP HOUSE DRIVE 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	FREDERICK If Under 1 Year If Under 24 Hrs.		FREDERICK	
	Funeral Director		216-04-0339 Usual Residence of Decedent	39 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y AUGUST 10	9. Birthpl Coun MAR	lace (State or Foreign try) YLAND
	72 hours after deeth with the Maryland neturel', or Items 23a or 28s-f show dical Examinat must be notified at		10a. State 10b. County	10c. City, Town or Lo			10	Od. Inside City Limits
	B Mar	ctor	MARYLAND FREDERICK	FRED	ERICK			1 X Yes 2 ☐ No
	ih th or 28	Funeral Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Coun	try?
	s 23a	ra	594 PUMP HOUSE DRIVE		21703	Ţ	JNITED STA	TES
	er de Item	nue	Armed F	cedent Ever in U.S. 13.1	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
36	irs aft	by F	1 Never Married 2 Married 1 Yes G 3 Widowed 4 Divorced Year or E	evi	1 ☐ Yes 2 💢 No Specify:		Specify: WHI	TE
Ö	2 hou	led	15. Decedent's Education	16a, Dece	dent's Usual Occupation	16	b. Kind of Business/Ind	lueto
215	within 7. ene. then 'n	pie	(Specify only highest grade completed) Elementary/Secondary (0-12) College ((Give	kind of work done during most of working DO NOT use retired)	na l	SELF EMPLO	- 1
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Z	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 Is marke any injury or other traumatic. 0068.	0.7	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Rura			
	1 and Health em 27 ther tr		William & Donna Miller/P 20a. Method of Disposition	20b. Place of Dispo	Pumphouse Dr./ Fre			
Baltimore,	Pages nent of int: If it		1 XBurial 2 ☐ Cremation 3 ☐ Removal from	State cemetery, cren	natory or other place)		. Location - City or Tov	
ᆵ	artme ortani injury	ļ, A	4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee		D SPIRES CEM 09/21			
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			23a. Part 1. Enter the disease, or complications that	caused the death. Do not enti-	er the mode of dying, such as cardiac o	r respiratory arrest,	ICK, PID 2	1702 Approximate
	Physician		Immediate Cause (Final	sacrimie.				Interval Between Onset and Death
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	/Medio	al	Julia H. Ma 4a. Facility Name (If not institution, gin				4b. City, Town, o	or Location of 0		nber 14,	2005 ty of Death	1030	
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	Funeral		Social Security Number 6.3			last birthday)	If Under 1 Year Months Days		Min. (Month, I	lirth Day, Year)	9. Birthp	lace (State or For ntry)	eign
	Director		123-03-6204 Usual Residence of Decedent		9	5 Trs.			Mar.	1910	Rus	sia	
	yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				1	0d. Inside City Lir	
	h the Maryland or 28e-f ehow	ctor	Maryland Montgom	ery	Che	vy Cha	se					1∰Yes 2□	No
	with th	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of		•	
	death with ms 23a or crivet be	eral	3507 Raymond Str	12. Was Decedent	Ever in U	S 13 V	20815	Hispanic Origin	n? (Specify Yes or N	United	State ace - Amend		
36	a # #	by Funeral Directo	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			f Yes, specify Cub 1 □ Yes 2💢 No	an, Mexican, F	Puerto Rican, etc.)		ack, White,	etc.	
2-0	72 hours natural',	Completed	15. Decedent's E (Specify only highest gr	ducation		16a. Dece	dent's Usual Occup	pation	t working	16b. Kind of I			
21	d within 7 giene. ir than "r the Mad	nple	Elementary/Secondary (0-12)	College (1-4or 5	5+)		kind of work done OO NOT use retire						
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Baltimore, Maryland 21215-0036	es 1 and 2 should be filed wolf Health and Mental Hygier filem 27 is marked other troumatic event, Ille	To Be	Roman Poliakoff						vermeil	e, maiden suna	1110)		
aryl	should ind Men marke	۴	19a. Informant's Name/Relationship			19b. Mailir	g Address (Street		or Rural Route Num	ber, City or Town	n, State, Zip	Code)	- 8
Ž	and 2 salth a n 27 ic		Anne Kefauver/Dau	ghter					, Towson	, Maryla	nd 2	1286	
ore	of He If item or oth		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 €	Removal from State	20b. F	Place of Dispo	sition (Name of natory or other pla	<i>сө)</i> Бе	eptember	20c. Location	- City or To	wn, State	
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Bal	permit. Pages 1 Department of F importent: If ite any injury or ot		21. Signature Funeral Service Lice 23a. Part1. Enter the disease, or con	Levy.	м00	003 B	ethesda,	Maryla	Robert A chase, Inc and 20814	1-3501	Wiscon	nsin Ave	nue
الاي/ 18760,	Physician /Medical Examiner be executed by physician and physician and the private transit tra	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CC Due to (or as b. Due to (or as c. Due to (or as d.	a consequence	(2.1)	Vaseu	lar	lseh	on .		Interval Betweer Onset and Death	
114/05 .0. Box 6	0 0	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	I death 3	Ectopic pregnanc Other (specify)	у			ate of delive	nry Day Year	
La 9	g 29	ρ	Part II. Other significant conditions	contributing to death b	ut not res	ulting in the u	nderlying cause gr	ven in Part I.				ne cause of death ably 4 ∐Unkno	
V, Julia	The law requires that the ete has been signed by the page 2 should be detache	Completed							24a. We aut per 1 □ Yes	formed?	. Were auto prior to cor death? 1 \(\subseteq \text{Yes}	psy findings availant pletion of cause	able of
/ita	ilcian: Th certificete rector, pag	Be (25. Was case reterred to medical examiner?						Death (Check only	one)			
000	Phys rthis ral di	lon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Impatie 28a. Date of Inju (Month, Da)		ER/Outpatien 28b. Time of Injury	28c. Inju			sidence 6 Ot how injury occu		1)	
Vansue	or A Direction by	Certification:	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	OB Class of Init	ury - At h	ome, farm, str	eet, factory, office		28f. Location	(Street and Num own, State)	ber or Rura	l Route Number,	
Mal	To the Hospital or within 24 hours after to the Funerel Direction completely filled in	edical C	29a. Certifier (Check only one) Certifying P Certifying P	hysicien: To the best miner: On the basis of and manner sta	f examina	owledge, death	n occurred at the treestigation, in my o	me, date and popinion, death	place, and due to th occurred at the time	e cause(s) and m e, date and place	anner as st	ated. the cause(s)	
	To the Ho within 24 To the Fu completel	Me	29b. Signature and title of certifier	0			29c. Licens			29d. Date sign			
•	4		· la	m/sa	-10	MA	D	005	7124	91	15	105	
_	121		30. Name and address of person who Truong Bao, M.D.	9715 Med	lical	Cente	r Drive,	#201,	Rockvill	e, Maryl	and	20850	
	Sta Regist		31. Date filed (Month, Day, Year) SEP 1 9 2	32/Registr	ar's Signa	ture Go	refer						

				artment of Health and Me	ntal Hygie	2005 SUUUN
			Decedent's Name (First, Middle, Last)		. Date of Death	3. Time of Death
	Physic /Med		GEORGE PAIGE		Month j	Day Year 24
	Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		3 2085 70 pm M 4c. County of Death
			LEVINDALE HEBREW GER. CEN	BALTIMORE, MD		BALTIMORE
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		Date of Birth (Month, Day, Yes	
	Director		236 - 38-8885 12M 20F 70 Yrs.	Months Days Hours Min.	8 - 15 -	
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Letter 1			
	Aaryt f sho	ō	i de disprison de la company			10d. Inside City Limits
	the A	Funeral Director	10e. Street and Number	imorre		1
	with a or	ā	FIRE CII	10f. Zip Code	10g.	Citizen of What Country?
	leath ns 23	era	5/29 Chalgrove Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21215		USA
"	fier d	I I	1 Never Married 2 Married 12 No	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	y Yes or No- an, etc.)	 Race - American Indian, Black, White, etc.
38	urs a	by	3 □ Widowed 4 □ Divorced If Yes, Give Year or Dates: 1953 - 56	1 ☐ Yes 2 ☐ No Specify:		Specify: RICE
21215-0036	within 72 hours after death with the Maryland ene. then "naturet, or items 23a or 28a-f show the Medical Examinar must be invitited at	Completed	15. Decedent's Education 16a Dece	dent's Usual Occupation	16h	Kind of Business/Industry
21,5	hin 7	pie	(Give	kind of work done during most of working DO NDT use retired)		•
7	filed with Hygiene. Ithar ther	NO.	4 College (1-401 54)	Laborer		Construction
pu	ba filed within 72 hours after death with the Marylan at Hygiene. ad other then "naturel; or items 23a or 28a-f show event, the Madical Examination in Milled at	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name (Fi		
Maryland	2 should ba filed withir and Mental Hygiene Is markad othar then aumatic event, I.A.M.	ြို	Robert Paige	Euni	ce F	aj g p
a	2 sho and is m	10.1	19a. Informant's Name/Relationship (Type, Print)	ng Address (Street and Number or Rural Ro	oute Number, City	or Town, State, Zip Code)
	s 1 and 2 should of Health and Meritem 27 is marks other traumatic		Jacquine M. Parge/WIFE 512	9 Chalgrove Aven	ive Ba	Itimone MD 21213
ore	0 0		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Dispo	sition (Name of Date matory or other place)	20c.	Location - City or Town, State
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Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Fine al Servicy Licensee 22	Name and Address of Facility	Funeral	Service PA
_	66500	0 /		Name and Address of Facility 1+ ari P. Cluse I 5126 Belain Roc	W. Butt	LOSIS OM enomi
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	ar the mode of dying, such as cardiac or re-	spiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	PANCREATIC CA.	air ro	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	ATTA CITE IT C	MEER	
	LAGITITIE	_	Sequentially list conditions, b.			
11	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Entai Underlying Cause (Disease or injury			
10	and I-tran	кап	trial initiated events C.			
8760,	cate be executed obysician and the burial-transit		Due to (or as a consequence of):			
387		dicai	d.			
×	certif iding se as	/Me	IF FEMALE: 23b. Was decedent organist 23c. If yes, outcome of pregnancy			
Вох	that the death certifi ed by the attending (detached for use as	Physician/Me	in the past 12 months?	Ectopic pregnancy		23d. Date of delivery Month Day Year
o.	the d y the iched	ıysi	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown 9 Unknown	Other (specify)		July 1 cal
<u>α</u>	that led b deta	P	Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause given in Part I	23e Did tohacco	use contribute to the cause of death?
S p.	uires sign	d by	CLOSTRIDIUM DIFFICILE COLITIS			2 ☐No 3 ☐ Probably 4 ☐Unknown
<u>0</u>	w requir	lete	POOR ORALL INTAKE			
Vital Records,	The law requires that the ate has been signed by the page 2 should be detache	Completed	FOUR DENDE INTIME		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
ā		e C	25. Was case referred to medical		1□ Yes 2€N	1 Yes 2 No
>	ysician: The is certificate hadirector, page	0 0	examiner?	26. Place of Death (Chi		
ō	ding Phy h. After this funeral c	PH 1	27. Manner of Death 28a. Date of Injury 28b. Time of	- La rearraing frome	5 Residence Describe how inju	6 ☐Other (Specify)
Division of	Attending Physician: r death. sector: After this certification by the funeral director.	ţ.	1 ☐ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	Describe now inju	ny occurred
N N	I or Attendate death Diractor: in by the	ifice	3 Suicide 6 Could not be		ocation (Street a	nd Number or Rural Route Number,
ā	el or A s after il Dirac id in by	Certification;	4 Homicide determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	2011	City or Town, Stat	e)
	To the Hospitel or Ai within 24 hours after of To the Funerel Dirac completely filled in by		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, and d	lue to the cause/s	and manner as stated
	he Ho n 24 he Fu	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or inventor and manner stated.	estigation, in my opinion, death occurred at	the time, date an	d place, and due to the cause(s)
	To t To tl		29b. Signature and title of certifier	29c. License number	29d. Da	ite signed (Month, Day, Year)
			Plum 14. wor scateury	D0063327	9/1	4105
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, P			
	2		(612-A6) WOLLD HUNT ALL 311211 11	0.500	mo, un	2/2/5
	Stat	~	31. Date filed (Month, Day, Year) 32 Pegistrar's Signature	and the same	, ,,	
	Registra	ir	31. Date filed (Month, Day, Year) SEP 1 9 2005	3		

State of Maryland / Department of Health and Mental Hygie 105 1 - For State Registrar 304**07** Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician September 15, Month Charles David Poehler 2005 /Medical 3:10 A™ 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charlotte Hall Veterans Home Charlotte Hall St. Mary's 5. Social Security Number 217-24-3128 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year, **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1XM 2□ F Director 75 Yrs. 1930 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hyglene. Proportant: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event. Its Medical Examinational to notified at once. or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Baltimore Directo Maryland Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Smeton Place, Apt. 300 Funerai 21204 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1947-49 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) manager manufacturing 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) George C. Poehler Charlotte P. Pfeltz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha S. Poehler/wife 1 Smeton Place. Apt. 3000 Towson, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Garrison Veterans Cem. Sep. 20,2005 Garrison, Maryland 22. Name And Address of Facility Wiedefeld Funeral Home, Inc Mitchell Wiedefeld Funeral Home, Inc Raltimore, MD 21212 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) /Medical Due to (or **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to or as as the burial-transit hank that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Day 5 Other (specify) Year ☐ Yes 2☐ No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? þ eq Completed 1 ☐ Yes 2 ☐ No 3 robably 4 🗀 Unknown has 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page autopsy performed? certificate 1 ☐ Yes 2 No uneral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification; To this 1 Inpatient 2 EP/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Hospital or Attending After 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 | Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of pe completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

ORIGINAL

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	Physicia	an	1. Decedent's Name (First, Middle, Last) Emm &	TT P	7		2. Date of Death Month Da		3. Time of Death
}	/Medic Examin		4a. Facility Name (If not institution, give stree COO SELMA 5. Social Security Number 6. Sex.	net and number)	SP. Ba	or Location of Death	40	County of Death	ace (State or Foreign
1	- Funeral - Director		327-16-4157 1XM Usual Residence of Decedent	20F 82	Yrs. Months Day	s Hours Min.	(Month, Day, Year	123 Vin	ginia
	ne Marylan Ba-f ehow	ctor	10a. State 10b. County	10c. Cit	Beetin	ñe			od. Inside City Limits 1 XYes 2 □ No
	e 23a or 2	Funeral Director	10e. Street and Number 4700 Harfund	Rd	10f. Zip Code	21214		itizen of What Count	F
900	within 72 hours after death with the Maryland ene. then "natural", or iteme 23a or 28a-f ehow Le Medicel Exercit or med Let collified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U Armed Forces? 1 Yes 2 No Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Co	f Hispanic Origin? (Specuban, Mexican, Puerto R lo <i>Specify</i> :	irry Yes or No- lican, etc.)	14. Race - America Black, White, e Specify:	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Itam 27 is marked other then "natural", or iteme 23a or 28a-1 ehow or other traumatic event, it a Medical Exertical retrinal to a collect returnation.	Completed	15. Decedent's Educat (Specify only highest grade of		16a. Decedent's Usual Occ (Give kind of work dor life, DO NOT use reti	ne during most of working ired) Dr. ver	B	Cind of Business/Ind Cettimine Sanita	tim city
Maryland	tould be filed Mental Hygin Marked other	To Be (17. Father's Name (First, Middle Last) Watter Park	am		Luven		leinber	-g
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Baltimore	Part Part		20a. Method of Disposition 1	loval from State	Place of Disposition (Name of temetery, crematory of other p	et ut 9-23	-05 M	ocation - City or Tov	is, nd
Bal	permit. Pa Departmer Important: eny injury		21. Signature of Fundatal Service Licens	4	Gange.	norch Frence	ual Home	Baeto. M	d. 21229
	Physician		23a. Part 1 Poter the disease, or complicat shock, or heart tellure. List only one of Immediate Cause (Final disease or condition resulting in death)	Worter	ited Visco	ying, such as cardiac or	respiratory arrest,	1	Approximate Interval Between Onset and Death
	/Medical Examiner	-	Sequentially list conditions b	Due to (or as a conseq	uence of):			9	-5-05
8760,	death certificate be executed e attending physicien and ad for use as the buriat-transit	al Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events causing in death) Last	Due to (or as a conseq					
9	entificate ding physi se as the t	/Medical	d	If yes, outcome of pregna	ancy			2012 115	
P.O. Box	the death certific y the attending p iched for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Il death 3 Ectopic pregnar			23d. Date of deliver Month	y Day Year
rds, P	The law requires thet the dealer has been signed by the a page 2 should be detached f	٥	Part II. Other significant conditions contrib	outing to death but not res	ulting in the underlying cause Demen	given in Part I.		use contribute to the	
Division of Vital Records,	ı: The law requ icate has been r, page 2 shouk	Completed					24a. Was an autopsy performed?	death?	sy findings available inpletion of cause of
of Vite	Physician: this certificatal director, p	To Be	1 L Yes 2 No		EN Culpatient 3 DOA		e 5 Residence		
sion	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the tuneral director, page 2	Certification:	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		☐Yes 2☐No	3d. Describe how inju		Pouts Mumber
D	pitel or A		4 Homicide determined	building, etc." (Specif			City or Town, Stat	e)	
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	Medical	29a. Certifier Check only one) 29b. Signature and title of pertifier	On the basis of examina and manner stated.	ation and/or investigation, in m	y opinion, death occurred	d at the time, date an	d place, and due to	the cause(s)
)	X \		· Khun		D	25391	Q	1-16-	05
1	t'X		30. Name and address of person who comp	leted cause of death (Item 5601	pwledge, death occurred at the attion and/or investigation, in minute in a second process of the second proces	aven BI	lud 13	altimore	mor1239
	Sta Registra		31. Date filed (Month, Day, Year) SEP 1 9 200	5 Manage	H Corte				

			For State	State of	of Maryl	and / Dep	artment o			Mental H	ygiene	000				
			Registrar 1. Decedent's Name (First, Middle	e, Last)			runcate c	Deau		2. Date of D	Reg. No.	005	3040			
	Physic		Hildelisa Per							Month	Day	Year	3. Time of Death			
>	/Medi Exami		4a. Facility Name (If not institution		ımber)		4b. City, Tow	n. or Location	n of Death	Septe		• 2005 ty of Death	5:45 AM M			
			Shady Grove Ad	lventist N	Jursin	у Ноте		Rocky				•				
	Funeral		5. Social Security Number	6. Sex	7. Age (In y	rs. last birthday,		ar If Unde	er 24 Hrs.	8. Date of B	irth	Mont g	omery lace (State or Foreign try)			
	Director		577-58-5380	1□M 2\\ F	93	Yrs.	Months Da	ys Hours	Min.	(Month, D	3, 1911		try) Cuba			
	and w]	Usual Residence of Decedent 10a. State 10b. County		100	City, Town or L	antin a				J, 1711					
	Aaryli Poho	ត	,		100.	Oity, rowit of Li	cation					10	Od. Inside City Limits			
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9	or Ite	Ē	1 Never Married 2 Marr	Armed Fo	orces?	10.	Was Decedent of If Yes, specify C	uban, Mexica	an, Puerto	Rican, etc.)	0- 14. Ha Bla	ce - America ack, White, e				
03	ours a	5	3	If Yes, Gi Year or D	ve lates:		1X∏Yes 2□1	No Specify	y:	Cuban	Specia		r71			
21215-0036	72 hours after death with the Maryland netural', or Items 23a or 28a-f show alsel Evarifret must be notified at	Completed by	15. Decedent (Specify only highes	's Education		16a. Dece	dent's Usual Oc	cupation			16b. Kind of B		White ustry			
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7	led w lygier lygier ther th			5-	+	Sup	erintend						chools			
and and	be fi	Be	17. Father's Name (First, Middle,	Last)				18. Moth	er's Nam	e (First, Middle	, Maiden Sumai	тө)				
3	a Mer narke	2		Waldo Per	rez						edes Sar					
Maryland	h and traum	65 5	19a. Informant's Name/Relationsh	,							er, City or Town,					
e,	1 and Healt em 2		Martha R. Ribas 20a. Method of Disposition	s/ Daughte		802 G1 D. Place of Dispo	and Cha	mpion					ry1and2085			
و	ages or o		1 X Burial 2 ☐ Cremation	3 Removal from		cemetery, crer	sition (Name of natory or other p	olace)		Date	20c. Location	- City or Tow	vn, State			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if Item 27 ie marked other then "netural", or Itema 23a or 28a-1 show any injury or other traumatic event, the Medical Evantral must be notified at ance.		4 Donation 5 Other (St	•		Oakwood	Cemeter	y	2/1	ember 2005	Falls C	hurch,	Virginia			
Ba	Depe Impo any ic		21. Signature of Funeral Service I))	+ MOI	0335	Rockvil Rockvil	lress of Facilities Inc. 12	nc. 3	ert A. 00 West	Pumphre Montgo	y Fun	eral Home/ Avenue			
			23a. Part1. Enter the disease, or shock or heart failure. List	complications that c	aused the de	eath. Do not ent	er the mode of d	ying, such as	ary iac	or respiratory a	rrest,		Approximate			
	Physician		Immediate Cause (Final	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Immediate Cause (Final												
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):													
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_	pe sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a cons	aquence of):										
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X 20 20	death certi e ettending id for use a	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐Live bi	irth 2 ☐ Fe ant at time of	tal death 3 🗆	Ectopic pregnan	су				te of delivery	ay Year			
	the d	Physician/M	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9□ Unkno		death 5	Other (specify)					5	uy real			
Z.	w requires that the di been signed by the should be detached	by P	Part II. Dther significant condition	s contributing to de	ath but not re	esulting in the un	derlying cause g	iven in Part I		23e. Did to	obacco use conti	ribute to the	cause of death?			
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ည်	28.5	D e		Advai	ice Ag	e				24a. Was	an 24b. V	Nere autops	v findings available			
ב -	age a	Completed									rmea?	leath?	y findings available pletion of cause of			
20.	certificete rector, pag	Be	25. Was case referred to medical examiner?					26. Place	of Death	1 ☐ Yes		☐ Yes 2	□ No -			
5 7	Q 50	၉	1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Ir	patient 2	☐ ER/Outpatient	3□ DOA O	44			lence 6 Othe	er (Specify)				
	After	ë	 Manner of Death Matural Pending 	28a. Date o (Month	f Injury n, Day Year)	28b. Time of Injury	28c. Inju	ury at			ow injury occurr					
NISION .	tor: /	cat	2 Accident investiga 3 Suicide 6 Could no	ation			M 1	Yes 2	No							
<u> </u>	or Attending Physician: ifter deeth. Director: After this certifical in by the funeral director.	Certification:	4 Homicide determin	ed Place	of Injury - At I g, etc. <i>(Spec</i>	home, farm, stre	et, lactory, office		2	81. Location (S City or Tow	treet and Numbern, State)	er or Rural R	Route Number,			
	ours a eral (29a. Certifier 1 Certifying	Dhadala T							,					
	To the nospital of Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical E	Physician: To the l xaminer: On the ba and manne		lowledge, death lation and/or inve	occurred at the testigation, in my	ime, date an opinion, dea	d place, a th occurre	nd due to the o	cause(s) and mar date and place, a	nner as state and due to th	ed. e cause(s)			
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	X					111)		MD58	597		Sentem	her 1	4, 2005			
6	2		30. Name and address of person w			4.67.4	•									
į	/		Shahryar Davar	i, M.D. 1	5225 S	hady Gr	ove Road	l, Sui	te 20	08, Rocl	kville,	Mary1	and 20850			
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			For State Registrar	State	of Maryla		artment of H tificate of I			giene Reg. No. 2005	30410	
	Dhuaisi		1. Decedent's Name (First, Middle, I	•					2. Date of De.		3. Time of Death	
	Physici /Medio		James J. Reynold	s						ber ^{Day} 15,200		
	Examin	er	4a. Facility Name (If not institution, g 20 Yew Road	ive street and nu	ımber)		4b. City, Town, or Essex		1	4c. County of De Baltimo		
	Funeral Director		5. Social Security Number 6 216–10–3638	Sex 1⊠M 2□F	7. Age (In yr. 86	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da April	th y, _{Year)} 9. B 11 , 1919 Ma.	rthplace (State or Foreign Country) ryland	
	pu *		Usual Residence of Decedent 10a, State 10b, County	_	10c (City, Town or Lo	cation				10d. Inside City Limits	
	short ed at	5	Maryland Baltimo	ro		ssex					1 ☐ Yes 2 ☒ No	
	28a-f	Director	10e. Street and Number			BBCA	10f. Zip Code			10g. Citizen of What 0	Country?	
	with		20 Yew Road				21221			U.S.A.	,,,,,,,	
	leath	era	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13. \	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (S	pecify Yes or No		nerican Indian,	
336	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other then "natural; or items 23e or 28e-f show other traumatic event, it a Madical Exerties must be natified at	by Funerai	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed F 1 Tes If Yes, G Year or I	2X No ive		f Yes, specify Cuba I ☐ Yes 2 /2 /√io	n, Mexican, Puert Specify:	o Rican, etc.)	Specific	ite, etc. hite	
Š	2 hou	ted	15. Decedent's	Education		16a. Deced	lent's Usual Occupa	ation	4.5.	16b. Kind of Busines		
215	hin 7.	pie	(Specify only highest of Elementary/Secondary (0-12)) (1-4or 5+)	life. I	kind of work done of OO NOT use retired	during most of wor)	king			
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pu	al Hygid d other	Be (•						Maiden Sumame)		
yla	should be on the should be on the short of t	To										
Maryland 21215-0036	d 2 sho h and 7 is mu traum	ñi	·			-1					Zip Code)	
	1 and 2 Health tem 27		20a. Method of Disposition		20b	Place of Dispo	sition (Name of	!	Date		r Town, State	
JOH.	Pages ent of nt: If i				State Pa				19,2005	Baltimore	. Marvland	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Helen Finck									
m	88188				\rightarrow		1407 old	Eastern	Avenue,	Essex, Mai	ryland 21221	
	Physician /Medical Examiner ithe prijelitansit	Examiner	23a. Part1 Enter the disease, or construction of the cause (Final disease of condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to	each line. 7777 (or as a conse	equence of):	c Pr	MATE W	e Ca	NCER	Intierval Between Onset and Death	
O. Box 68760,	the death certifi y the attending ched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	utcome of preg birth 2 □ Fe nant at time of nown	tal death 3	Ectopic pregnancy			23d. Date of do	blivery Day Year	
rds, P		by	Part II. Other significant conditions	contributing to	death but not re	esulting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use contribute res 2 No 3 F	to the cause of death? Probably 4 Unknown	
Vital Records,	: The law requires cate has been sign page 2 should be	Completed							24a. Was autop perfo 1 Yes	an 24b. Were a prior to death? 2 No 1 Yes		
Vita	ysician: Th	Be	25. Was case referred to medical examiner?	Hospital:			Othe	ar	th (Check only o			
of	S S =	7°	1 Yes 2 Solo 27. Manner of Death	1		ER/Outpatien 28b. Time of	I 3L DOA	4 🗀 Nursing H		dence 6 Other (Sp.	ecify)	
Division	tending leath. tor: After the fune	27. Manner of Death Color Color									Rural Route Number,	
	tospita thours unerel	edicai Ce	29a. Certifier Certifying (Check only one)	Physician: To the aminer: On the land man	e best of my ki	nowledge, death	occurred at the time restigation, in my op	ne, date and place pinion, death occu	, and due to the orred at the time, or	cause(s) and manner a date and place, and du	is stated. e to the cause(s)	
)	To the P within 24 To the F complete	Me	29b. Signature and time of cartifier	Sula	ude		29c. License			29d. Date signed (Mon	1	
1	7,		30. Name and address of person wh	completed call	So of death (it	вт 23a) (Тура)	Print) / 75	v5 0s	USA D	n- Tow so	NMO 212a	
	Sta Registr	-	31. Date filed (Month, Day, Year) SEP 1 9	2005	Registr's Sig	nature	porte					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** SEPTEMBER 13, 2005 ALBERT RIDGES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE WINDSOR MILL 7404 RIPPLE COURT If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. APRIL 15, 1914 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1₩ 2□F SC Yrs. 218-14-7523 91 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location in than "natural", or Itama 23s or 28s-f show the Medical Exempler must be notified at 1√XYes 2 No Directo WINDSOR MILL MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21244 USA 7404 RIPPLE COURT 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ s 2 □ No It X s, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 X Vidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed within at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) US PUBLIC HEALTH HOS. COOK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other treumatic avent CARRIE BLAIR ANDREW RIDGES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21244 JACQUELINE THORNTON/DAUGHTER BALTIMORE, MARYLAND 7404 RIPPLE COURT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition tXXBurial 2 ☐ Cremation 3 ☐ Removal from State 9-20-05 BALTIMORE, MARYLAND WOODLAWN CEMETERY * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. BALTIMORE, MARYLAND 21217 1701-31 LAURENS ST. mes 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic prostate 2 425 Cancer /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) led by the attending physicien end detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ Chronic neuol failure on Hemoelealysis 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Hypertension 24a. Was an this certificate has autopsy performe 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 PResidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🗹 No Certification; To 27. Manner of Death 1 L Natural 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b Time of After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Division of Vital To the Hospitel or Attending within 24 hours after death.
To the Funerel Director: After

P.O. Box 68760.

within 72 hours after

Baltimore, Maryland 21215-0036

Registrar

OETAI MIS 31. Date filed (Month, Day, Year) SEP 1 9 2005



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

of DESHI NO

Maidenchoice lane

D 30494

Baltimore MD

9-14-4005

41218

DHMH 17 Rev 1/2001

2005

SEPTEMBER 11,

ELEANOR ROSSI

G.		-	State Unpend Item 23a	State of Maryland / a,27,28a-f per	Depa me Cer	rtment of He 1847 28 tificate of L	ealth and 05 tas eath	Mental Hy	gien 2 0 0 5	30413
	Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of De Month		3. Time of Death
	/Medic	al	Barry G. 4a. Facility Name (If not institution, give stre	Sheppard	1	4b. City, Town, or I	ocation of Dea	Septem	ber 13, 20	5:56 A M
	Examin	er	1968 Sidnee Drive	or and manustry		Edgewood			Harfor	
0	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last i			If Under 24 Hrs Hours Min	. (Month, Da	th y, Year) 9. E	Birthplace (State or Foreign Country)
2	Director	-	212-76-3014 XXXX	1 2 □ F 4 2	Yrs.			11/30		laryland
9	Maryland -f ehow		10a. State 10b. County	10c. City, To	wn or Lo	cation				10d. Inside City Limits
	80-f et	ctor	Maryland Harford	Edge	wood	1				1 ☐ Yes 2X No
	with th	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	ns 23	eral	1968 Sidnee Drive	Was Decedent Ever in U.S.	13. \	21040 Vas Decedent of His	panic Origin? (Specify Yes or No		merican Indian,
9	s 1 and 2 should be filed within 72 hours after death with the Maryler if Health and Mental Hygiens the flow or tiems 23s or 28s-1 show item 27 is marked other tream "naturel", or tiems 23s or 28s-1 show other treamatic event, the Madical Examinar must be notified at		1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give		f Yes, specify Cuban I□Yes 257 No	Specify:	no Hican, etc.)	Black, W Specify:	hite, etc.
21215-0036	hours ture!',	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educat	Year or Dates: 1981		lent's Usual Occupat	tion			White
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212	ed with	Completed	12	5	Stee]	Fabricat			Steel Man	ufacturing
and	ntal Hy ad oth	Be	17. Father's Name (First, Middle, Last)	7					, Maiden Sumame)	
Maryland	should nd Me mark mark	은	Robert Garland Sh 19a. Informant's Name/Relationship (Type	neppard	9b. Mailir			Jean Bowy Jural Route Numb	er, City or Town, State	a, Zip Code)
	and 2 alth ar 27 io		Nancy Lynne Sheppar			Sidnee Dr	rive Ed	dgewood,	Maryland 2	21040
altimore,	ges 1 at of He if item or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Ren	ceme	of Dispo tery, crer	sition (Name of natory or other place	9	Date /17	20c. Location - City	or Town, State
Iţim	permit. Pages Depertment of importent: if if eny injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee			L1 Mem. Ga		/17 005	Baltimore	, Maryland
Ba	Depermine Depermine on impo		Michael C. Ja	11,00 50		ruzdzinski		l Home E	PA Essex. Mary	yland 21221
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	tions that caused the death. D	o not ent			c or respiratory a	rrest,	Approximate Interval Between
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1	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):					
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	be executed icien and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last							ļ
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Вох	death certific e attending p id for use as	by Physician/M	23b. was decedent pregnant	. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	ath 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
	0 0 0	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5[Other (specify)			Note	Day (Gal
P.O.	requires that the d een signed by the hould be detached	y Ph	Part II. Other significant conditions contri	buting to death but not resulting	g in the u	nderlying cause give	n in Part I.	23e. Did t	obacco use contribute	to the cause of death?
rds	w requires been signi should be							10	Yes 2 No 3□	Probably 4 Unknown
ecc	aw as b	Completed						24a. Was	psv prior	autopsy findings available to completion of cause of
Vital Records,	The ate							1 70 res		es 2□ No
	Physicien: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ★★es 2 □ No	spital: 1 Inpatient 2 ER/	Outpatier	t 3 DOA Othe		eath (Check only only only only only only only only		pecify)at scene
Division of	ding Phy h. After thi funeral c	T:T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury 28t	. Time o				how injury occurred	unk
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Divi	i or Attuefter de Directo	Certification:	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify) found at home	, iarm, sir	еет, гастогу, опісе		City or To	wn, State) 1968 d, Marylar	Sidnee Drive
	To the Hospital or Attent within 24 hours effer deati To the Funeral Director: completely filled in by the	edical C		tian: To the best of my knowled r: On the basis of examination and manner stated.				e, and due to the	cause(s) and manner	as stated.
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed (Mo	onth, Day, Year)
	,		Thirdul	4 K-8-	w	0.C.M	.E.		September	13, 2005
ħ	\prec		30. Name and address of person who com		a) (Type,					
U	Sta	te.	THE OWNE M(K. 31. Date filed (Month, Day, Year)	32. Restrar's Signature	1	II Penn Si	treet,	Baltimore	e, Marylan	d
	Registr		SFP 1 9 20	05 Mesus A	JE A	20346				

10

State Registrar

9000 Franklin

32. Registrar's Signature

Square Drive Baltimore MD 21237

30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

Jim Parshall

SEP 1 9 2005

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** sent 05 DANIEL ALBERT SPEAR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY N/A UNION MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 3/18/1944 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 12 M 2 ☐ F Yrs. 219-42-7081 61 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Worle r than "neturel", or items 23a or 28e-f ehov the Medical Examinational be pullified at 1 Yes 2 No Director BALTIMORE PARKVILLE MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 8700 LOCH BEND DRIVE 21234 APT. D USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 ☐ Yes 2 🔏 No If Yes, Give Year or Dates: hours after 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. ELECTRONICS Elementary/Secondary (0-12) College (1-4or 5+) ELECTRONICS TECHNICIAN 2 YEARS MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GEORGE HAZEL SPEAR SELMA DEICHMILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID W. SPEAR/BROTHER 21129 SLAB BRIDGE RD. FREELAND, MD other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Durial 2 Cremation 3 Removal from State ö permit. Page Department of importent: if eny injury or once. BETHEL CEMETERY 9/19/2005 S. CHESAPEAKE CITY, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Colon CA 4 Liver mets years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit The law requires that the death certificate be executed Renal Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year ò in the past 12 months? 5 Other (specify) ☐Yes 2☐No of Vital Records, P.O. detached 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. be 3 ☐ Probably 4 Winknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No 24a. Was an page 2 1 ☐ Yes 2 No ector, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Da e of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred in by the funeral 27. Manner of Death To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After Division 1 Natural 2 Accident Inius 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 THomicide Pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) BUSU, 29b. Signature and tiftle of certifier MD Sent 15, 2005 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Memona Hospital Unio n mok. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 9 2005

State of Maryland / Department of Health and Mental Hygien 2005 30416 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** September 11, 2005 Marilyn Jean Senko 3:35 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. June 19, 1940) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
0h10 **Funeral** Months 1 □ M 2 🔀 F 65 Director 296-36-1828 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or iteme 23s or 28e-f ehow the Medical Examinar must be notified at Director 1 ☐ Yes 2X No Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12104 Lauderdale Drive 20852 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after de al Hygiene. other then "naturel", or Item 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygient Importent: If Item 27 is marked other the event event injury or other treumatic event 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Roth Freida Lingner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denis D. Senko/Husband 12104 Lauderdale Drive, Rockville, Maryland 20852 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery 20a. Method of Disposition 20c. Location - City or Town, State September 1 Burial 2 Cremation 3 Removal from State Crematorium, Inc. Bethesda, Maryland 4 □ Donation 5 □ Other (Specify) 15, 2005 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signatur 15 eral 5 rvice Licensee M01353 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** oneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner latera amyotrophic sclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in titlated events resulting in death) Last Due to (or as a consequence of). Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 200 No Yes 2□ No 1 ☐ Yes To the Hospital or Attending Physician: "within 24 hours efter death." To the Funeral Director: After this certifica : After this certifications and funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □ Yes 25 No 1 Inpatient 2 ER/Outpatient ٩ 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD September 14, 2005 D59738 licia J. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 9 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 0 5 1 - State Registre Certificate of Death Dayt 2005 1. Decedent's Name (First, Middle, Last) 2. Date of Death STARKS **Physician** LYDIA 2.40 M.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Randallstown Baltimore Northwest Hospital Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 8. Date of Birth | Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 😾 F 89 217-07-8784 Sept 15,1916N. Jersey Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f show or other treumatic event, the Medical Examiner must be notified at 1 ☐Xes 2 ☐ No N/A Baltimore Maryland Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 4005 Dorchester Road USA Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 XNo Specify: ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Church Years Minister 18. Mother's Name (First, Middle, Maiden Sumame 17. Father's Name (First, Middle, Last) Be Goldie Iantha Reesby Joshua Henry Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Randallstown, Maryland 21133 Rodney G. Starks/ Box 1110 P.O. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Calvary Cemeter 9/22/05 1 Burial 2 Cremation 3 Removal from State Brooklyn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Egneral Service Licenta 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 25a. Part I. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical PANCREATITIS **Examiner** ACUTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed the burial-transit Due to (or as a consequence of) P.O. Box 68760 signed by the attending physician Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ENCEPHALOPATHY 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 1 ☐ Yes 2 ☐ No 25 No Hospitel or Attending Physicien: 24 hours after death. Funeral Director: After this certifica funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ို 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 2 Natural 5 Pending 1 Tyes 2 🗆 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospitel within 24 hours a To the Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) Sept 15Th 2005 29c. License number D54288 Northwest Hyspital Center. 39-Name and address of person who completed cause of death (Item 23a) (Type, Print) Hamaswamy Registrar's Signature 31. Date filed (Month, Day, Year) State Dan & Sports 7 2005 Registrar DHMH 17 Rev 1/2001

		•	1 - State of Marylar State of Marylar Registrar		artment of Health and rtificate of Death	Mental Hygie	71115	30418
			Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		MARJORIE DEGRAW	STU	LL		5 2005	12:24 PM
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea	th	4c. County of Death	
			4529 CHERRY TREE LAN		SYKCSUILLE If Under 1 Year If Under 24 Hr.	S	CARRO	
	Funeral		20 1 1200 1 1 M 20 F 79	. last birthday) Yrs.	Months Days Hours Mir	(Month, Day, Ye	ear) _ Cou	place (Stete or Foreign
	Director		Usual Residence of Decedent			10026	1923 1111	ARYLAND
	yland		10a. State 10b. County 10c. C	ity, Town or Lo				10d. Inside City Limits
	Mar B-f st	to	MO CARROLL	SYKE	SVILLE			1 Tyes 2 No
	or 28	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cou	ntry?
	death with the Maryland rms 23a or 28e-f show rms 1.e. notified at		4529 CHERRY TREE.		50'		USA	
	er dez	Funeral	11. Marital Status 12. Was Decedent Ever in the Armed Forces?	J.S. 13.	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ameri Black, White,	
30	hours after urel', or ite	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No If Yes, Give 1 3 ▼ Widowed 4 □ Divorced Year or Dates:		1 ☐ Yes 2 XNo Specify:		Specify: Wh	ite
2-003b	within 72 hours after death with the Marylan flene. r then "naturel", or Items 23a or 28e-1 show The Medical Examiner must be notifiled at	ed	15. Decedent's Education	16a. Dece	edent's Usual Occupation	168	o. Kind of Business/In	dustry
<u>က</u>	within 72 ene. then "nat	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		e kind of work done during most of wo DO NOT use retired)	orking (LUTOMOT	
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<u> </u>	al Hy al Hy 1 oth	Be (17. Father's Name (First, Middle, Last)			ıme (First, Middle, Mai		
<u>S</u>	Ment Ment arked	ဥ	CHARLES DEGRAW	_		MA BRU		
<u>a</u>	l 2 sh and r ie m		19a. Informant's Name/Relationship (Type, Print)	0.00	ing Address (Street and Number or F			
e,	s 1 and f Health item 27 other t		CHARLES STULL / SON 20a. Method of Disposition 20b.	Place of Dispe	Lemon tree Dr.		Location - City or To	
و	0		Zod. Wolfied of English	cemetery cre	matory or other place)			
Bairimor	그 든 원 근		' 4 □ Donation 5 □ Other (Specify) 50 21. Signature of Funeral Service Licensee /	2	ARROII CREM 9/	IN Zum B	UN EH	A mon Co-
g	Depart Import any in		Jeffy V. Zumbrun		5028 Sytesville	Road E	LOUIS BURG	M 21784
			23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.					Approximate Interval Between
	Physician			والملاء	c Lung conce		1	Onset and Death
	/Medical		resulting in death) Due to (or as a conse		t Long Conce			
	Examiner		Sequentially list conditions, b.					
	ed sit	ine	if any, leading to immediate Due to (or as a conse	quence of):				
_	xecut and II-tran	Examiner	that initiated events c. Due to (or as a conse	equence of):				
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X Q Q	eath certific attending p I for use as 1	hysician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fel		☐Ectopic pregnancy		23d. Date of deliv	*
	s deat he att ed for	sicie	in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnant at time of		Other (specify)		Month	Day Year
J.	at the de d by the a etached	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not re	autina in the	underkring govern given in Dort I	23e Did tobac	co use contribute to t	ne cause of death?
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Kecords,	hast hast	Completed				24a. Was an autopsy performed	prior to co	psy findings available mpletion of cause of
			OF Was seen referred to modified		00 Plans (D)	1 Yes 2	No 1 ☐ Yes	2X No
VII		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	☐ ER/Outpatie	Other	eath <i>(Check only one)</i> Home 5 Y Residence	e 6 □Other /Specia	iv)
Ö	y Phye er this eral di	-	27. Manner of Death 28a. Date of Injury	28b. Time o		28d. Describe how i		,,
<u> </u>	Attending F death. ctor: After y the funera	atio	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury	M 1 Yes 2 No	4		
UIVISION	r Atte er dei recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spec		treet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura itate)	al Route Number,
5	apitel or ours afte nerel Dir filled in					ļ		
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying Physician: To the best of my kr (Check only onl) Medical Examiner: On the basis of examinari and manner stated.					
	To the Hoe within 24 h To the Fur completely	Med	one) and manner stated. 29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month,	Day, Year)
	/		DOB - MO		PFIFZOND		teuse 17	
	1		30. Name and address of person who completed cause of death (Ite	am 23a) (Type	Print)			1
	5		SCOTT ZUFF MD 1380 Progress	Liky S	suite 100 Ecolers	and pric	21784	
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Sign		,			
L	Registr	ar	SEP 1 7 2005	H. As	ode		<u></u> -	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 0 0 5 30419 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Dennis Joseph 6:12 a Smith Sept. 11 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Chevy Chase 3102 Brooklawn Terrace If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 → M 2 □ F 370-56-8861 53 Director 31, 1951 Saginaw, Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. Item 27 tems 23s or 28e-f show then 27 temsets other than "natural", or items 23s or 28e-f show other treumstic event, the Medical Example or man be notified at 10a. State 10b. County 1 Yes 2 □ No Be Completed by Funeral Director MD Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3102 Brooklawn Terrace 20815 United States 12. Was Decedent Ever in U.S. Amed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No white If Yes, Give X Year or Dates: Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Telemarketing/Comm. President 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Louis \mathbf{F}_{\bullet} Smith Eloise L. Blondin Smith ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Louanne M. Smith 9221 Wendell Street, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 5 E 1 ☐ Burial 2 ☐ Gremation 3 【☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ò permit. Page Depertment of Importent: if any injury or Merrill, Michigan Superior Crem. Svs. 9/17/05 21. Signature of Funeral Service Licensee Mapp Funeral and Cremation Services 22. Name and Address of Facility 933 Gist Avenue Silver Spring, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cardiopulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Coronary Artery Disease as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien End Stage Renal Disease IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown ģ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? Sec page 2 autopsy performed? this certificate 2 3NO 1 🗌 Yes 2 No 1 Yes Hypertension To the Hospitel or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: After 5 Pending M 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours efter deat To the Funerel Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9-12-05 D0060036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1299 Lamberton Drive, Silver Spring, MD Dr. Mahoud Doski 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar 2005

			1 State	artment of Health and Mental F	2005 00100
			1. Decedent's Name (First, Middle, Last)	2. Date of	
	Physici		Dorothy Marie Tregoe	Month Sente	
Fig. 207	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Manor Care Health Services	Rossville	Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Months Days Hours Min. (Month,	Day, Year) Country)
	Director		220–16–6290 81 Yrs. Usual Residence of Decedent	March	n 8, 1924 Pennsylvania
	yland		10a. State 10b. County 10c. City, Town or L	ocation	10d. fnside City Limits
	ith the Marylar or 28e-f show	ctor	Maryland Baltimore Middle F	River	1 ☐ Yes 2 X No
	ith th	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	ath w		3805 Clarks Point Road	21220	U. S. A.
	ltams	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes or ff Yes, specify Cuban, Mexican, Puerto Rican, etc.)	r No- 14. Race - American Indian, Bfack, White, etc.
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re,	gas 1 and 2 should be filled within 72 hours attar death with the Maryla It of Health and Mantat Hygiens. If item 27 Is marked other than "natural", or Items 23a or 28e-f show or other traumatic event, the Medical Example mouth to colline a		20a. Method of Disposition 20b. Place of Disposition cemetery, cre	matory or other place)	20c. Location - City or Town, State
Ē	Pa ant ary		Y Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Oak Lawn	Cemetery 9/17/2005	Baltimore, Maryland
Baltimore,	permit. Pagas 1 and Department of Health Important: If item 27 any injury or other tr		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue	PA Essex, Maryland 21221
			23a Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respirator	ry arrest, Approximate
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	/Medical Examiner		resulting in death) Due to (or as a consequence of):	1. 1. Ca. Di isa	Onset and Death (year cular disense 10 your
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ita	sician: Th cartificate rector, pag	Bec	25. Was case referred to medicaf examiner?	26. Place of Death (Check on	
of V	hys this at dir	မှ	1 ☐ Yes 2X No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient		esidence 6 Other (Specify)
		Certification:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of fnjury	of 28c. Injury at 28d. Describ Work? M 1 ☐ Yes 2 ☐ No	be how injury occurred
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Ω	after after Dirac	ertii	4 Homicide determined building, etc. (Specify)		Town, State)
	To the Hospital or Attanding within 24 hours after daath. To the Funerel Diractor: Afta complataly filled in by the fune	ical	29a. Certifier (Check only one) Certifying Physician 19 the best of my knowledge, deat 2 Medical Examiner On the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occurred at the tim	ne, date and place, and due to the cause(s)
	To the within To the somple	Me	29b. Signature and title of certified	29c. License number	29d. Date signed (Month, Day, Year)
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1	0 1		30. Name and address of person who completed cause of death (Item 23a) (Type.	Print) Blied RoDI	14D. 2/23/
l			ESSEX medical center, 404 Es	when Diva, 1sal 7	wire visited
	Sta Registr	ite ar	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type. 31. Date filed (Month, Day, Year) SEP 1 9 2005 32 Registrar's Signature	MAGE	

State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registrar 30421 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Michael Thaden 12:29 September 13, 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F Months Days Hours Director 578-48-6789 68 August 4, 1937 Washington, D. C. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other then "natural", or Items 23a or 286-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🙀 No Director Maryland Montgomery Rockville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Orchard Way North 20854 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Builder Remodeling 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward H. Thaden Mary Helen Hummer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 I 7 Orchard Way North, Rockville, Maryland 20854 Elizabeth M. Thaden/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot once. September 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc 15, 2005 * 4 □ Donation 5 □ Other (Specify) Bethesda, Maryland 21. Signature of Fuperal Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. Ungelette Barri M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COTONON **Physician** Tyears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No detached the 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Liakmown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 1 ☐ Yes 2 No 2 🗌 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Dupatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 📆 № 0 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. I Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Spplenber 13, 2005 D0057032 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kunkunna, celle Exentur Bluck, Suite 155, Ruckville, 415 20852 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 9 2005 Registrar

			For State Registrar	*	artment of Health and M rtificate of Death	ental Hygie	Z 11 115 3 11 11 2 2
	Physici		1. Decedent's Name (First, Middle, Last) Zoe C. Vette				Day Year P M
	/Medic Examin		4a. Facility Name (If not institution, give str	eet and number)	4b. City, Town, or Location of Death	Sept 1	6, 2005 11:50 4c. County of Death
	- Adrijin	Ų.	1008 Parade Lane		Mount Airy		Carroll
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday,	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director		425-54-9753 Usual Residence of Decedent	75 Yrs.		Sept 21	, 1929 LA
	land ow		10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
	Many a-1 sh	tor	Marvland Carrol	1 Mount	Nirv		1 ☐ Yes 2 ☐ No
	or 28.	Funeral Director	Maryland Carrol 10e. Street and Number	1 Mount	10f. Zip Code	10g.	Citizen of What Country?
	ath w 23a	rai	008 Parade Lane		21771		ited States
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36	urs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕱 No If Yes, Give X Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: White
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anc	ould be fi Mental H arked ot atic ever	Be c	Harold Frederick	Cashmore	Mary O.	_	uen Surname)
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altimore,	es 1 al of Hea of item fitem		20a. Method of Disposition	20b. Place of Disp			. Location - City or Town, State
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ä	permit. Page Department Important: Il any injury o		21. Signature of Funeral Service License		2. Name and Address of Facility	oral Do	me and Crematory
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Ī,			shock, or heart failure. List only one	cause on each line.			proximate Interval Between Onset and Death
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Division of	or Atteno	ertification;	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, st	reet, factory, office 2		t and Number or Rural Route Number,
ă	al or A s efter N Direct	Cert	4 Homicide determined	building, etc. (Specify)		City or Town, S	7218)
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	with To Con	Σ	29b. Signature and title of certifier		29c. License number	4	Date signed (Month, Day, Year)
	10		20 November of the second seco	polotod course of drawn (the constant)	1) - 5M12		1127/2003
	p /		30. Name and address of person who com		Sumpoun Tik	s, fre	1/19/2005 DEMICH MD 217UZ
	Sta Registr		SEP 1 9 200	32. Registrar's Signature	Garles		

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	Dhysiai	an	1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic		Rose Mary Weber						Septemb			2:05 PM
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 1412 Hopewell Avenue Essex								inty of Death ltimore	2
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.					If Under 24 Hrs.	8. Date of Birth (Month, Day	1		lace (State or Foreign try)
	Director		213–16–4296	M 2XXF	83 Y	rs.	Months Days	Hours Min.	Sept. 25	,1921	India	ina
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loc	ation				1	0d. Inside City Limits
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7	ithin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)			luring most of workir)				10.
7	led willygien her th		11 17. Father's Name (First, Middle, Last)		Ja	mit	or	18. Mother's Name	-			Company
ב ב	d be fi	Be c	Philip Hopper					Ruth Whi		Maiden Sun	rame)	
Ž	shouid nd Me mark mark	٦ ک	19a. Informant's Name/Relationship (Type	ое, Print)	19b.	Mailing	Address (Street a	nd Number or Rura	l Route Numbe	r, City or To	wn, State, Zip	Code)
Ž	alth ar		Phyllis Hagan (Daug	ghter)	1	412	Hopewel	l Avenue,	Baltim	ore, N	Marylar	nd 21221
ת ת	es 1 a of He fitem rothe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R	emoval from State	20b. Place of cemetery	Disposi	ition (Name of atory or other place	9}			on - City or To	
	Pag ment tant: i		`4 □Donation 5 □Other (Specify)	emovarnom State	Oak La		Cemetery	, ~				Maryland
מם	permit. Pages 1 and 2 should be Illed within 72 hours after death with the Marylan Deparmit of Health and Menhal Hygiens. Important: if Item 27 is marked other yethen "natural", or thems 23a or 28a-1 show any injury or other traumatic event, It a Me Jical Exacting chart be multified at once.		21. Signature of Euneral Service License	ne S		22.	Name and Addres Br 407 Old	^{s of Facility} uzdzinski Fastern A	Funera venue,	l Home Essex	e, p.A. Mary	and 21221
			23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the cause on each line	ne death. Do no							Approximate Interval Between
	Pnysician :	F 15	Immediate Cause (Final disease of condition					Druca			(Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	conseque ce o	f):	0	M. H. Charles of the				- C
	Ladimine	Sequentially list conditions b.										
	uted I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury			.,.						
<u>,</u>	execu in and rial-tra	Еха	that initiated events cresulting in death) Last	Due to (or as a	consequence of	f):						
,00700	ficate be executed physician and s the burial-transit	edicai	d									
Š	ertifica ling ph	Med	IF FEMALE:	3- K								
200	w requires that the death certif been signed by the attending should be detached for use a	Physician/M	in the past 12 months?	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti	Fetal death		Ectopic pregnancy Other (specify)				Date of delive Month	ry Day Year
j	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	ino of doutin		Cition (apociny)					
L .	s that ined b e deta	by Pł	Part II, Other significant conditions con	1 0			derlying cause give	n in Part I.	23e. Did to	Dacco use co	ontribute to th	e cause of death?
CI CO,	en sig	ted t	Hypercholes	Herole	ma				1 Y	es 2□No	3 Proba	ably 4 Dunknown
ט ט	law reas be	Completed							24a. Was a autops	iv	prior to con	osy findings available oppletion of cause of
<u>د</u>	rsician: The law s certificate has b lirector, page 2 s	Con							perform 1 Tes	ned? 2 No	death?	2 🗆 No
VILA	ician certifi rector	Be	25. Was case referred to medical examiner?	ospital:			3CLDOA Othe	26. Place of Death				
5	Phys r this ral dii	: To	1 Yes 2 No	28a. Date of Injury	2 ER/Outp	ime of	28c. Injury	at 2	ne 5 Reside 8d. Describe ho)
5	nding ath. r: Afte e fune	atior	1 ■ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	rear) In	jury	Work M 1□Y	? ′es 2 □ No				
2	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	y - At home, fars (Specify)	m, stree	et, factory, office	2	8f. Location (SI City or Town		mber or Rural	Route Number,
2	ital o urs aft orai Di lled ir	Cer										
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of er: On the basis of e and manner state	xamination and							
	ro the within romple	Med	29b. Signature and title of certifier	and marrier state			29c. License	number	2	9d. Date sig	ned (Month, L	Day, Year)
			RALMA	MAN	D		D000	00088		9/11	1/05	
	47		30. Name and address of person who con	mpleted cause of dea	ith (Item 23a) (T	Гуре, Р			1			
	' '		Rachelle Smit	LIMD 17	45 ED	not	ein Bl	o, bal	non	e, M	1) 21	122
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 9 200	5 Hegistrar	S SIGNALUTE	A COL	els.	o, Bal				
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2005 30426 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1:05 EVERETT WILLIAMS Sept 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SYKESVILLE CARROLL 4696 Scotsworth WAT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Min. Months Days Hours 15€M 2□F Yrs. 5742478 52 MARYLAND Director 20 195 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show event, the Medical Examiner must be notified at SYKESVILLE 1 Yes 2 No mo CARROLL Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Itams 23a or 21784 WAY USA 4696 Scotsworth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 S No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 5 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: white 2 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event. If a Mental 2006. Fleck Machine Elementary/Secondary (0-12) College (1-4or 5+) PRODUCTION MANAGER COMPAN) 12 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Everett Williams Catherine ပ္ Charles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sykesville mo 21784 V. Williams 4696 Scotsworth WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 17/2005 Winfield South Carroll Cren 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee JN ZUMBRUN EHEMON. Co HOPEN NO Rd 11c 21784 SYKES umbrun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 month Meta **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, hed by the attending physician detached for use as the buria Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. director, page 2 should be 1 X Yes 3 Probably 4 Unknown 2 🗌 No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Jas certificate 210 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Vasidence 6 Other (Specify) Hospital: 2 No 1 🗌 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA Medical Certification; To this funeral 28d. D scribe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 27. Manner of Death After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after deatl To the Funaral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. the 29c License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 00 mpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person 1650 Orleans Street Baltimore Maryland 21231 Day, Year) 31. Date filed (Month) 32 Registrar's Signature State Registrar

	- 1	State Registrar		laryland / D	Certificate				-	eg. N2 ()	05	3042
ician		1. Decedent's Name (First, Middle, La	ast)					2	. Date of Deat Month	th Day	Year	3. Time of Dea
dica		Akilah M. Austin							eptember			11:55
nine	r, '	4a. Facility Name (If not institution, git	ve street and number	7)	4b. City, T	Fown, or L	ocation of	Death		4c. Count		
		The Johns Hopkins Ho 5. Social Security Number 6.		ge (In yrs. last birth	Baltin day) If Under 1		If Under 24	Hrs. 8	Date of Birth	Balti		County hplace (State or Fo
al or			1 □ M 2 □ F	1 Y	Months			Min.	Date of Birth (Month, Day, January	Year) 7 2004	Co	untry) 'land
"	-	Usual Residence of Decedent		·				`		. ,	1 7	
4		10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Li
1	Į.	Maryland Anne Arun	del	Glen Bur	nie							1 Yes 2
Director	ě	10e. Street and Number			10f. Zip (Code			1	0g. Citizen of	What Co	untry?
		130 Marie Avenue			210					United	State	5
2	runeral	11. Marital Status	12. Was Deceder Armed Forces		13. Was Decede If Yes, speci	ent of His	panic Origii , Mexican, I	n? (Specif Puerto Ric	fy Yes or No- can, etc.)	14. Ra Bla	ce - Ame	rican Indian, e, etc.
ū	y r	1 Never Married 2 Married	1 ☐ Yes 2 ⊠ If Yes, Give		1 ☐ Yes 2	No 🍱	Specify:			Speci	fy: B	i Racial
7	Ω -	3 Widowed 4 Divorced	Year or Dates		No codent's Heuri	I Convent	ion		1	16b, Kind of 8	Zucinosc/	Industry
1010	Completed	15. Decedent's E (Specify only highest gr	ducation rade completed)	- (Decedent's Usual Give kind of work life. DO NOT use	k done du	uring most o	of working		100. Kind of a	ousiness	industry
E	Ē	Elementary/Secondary (0-12)	College (1-4o	75+)		0 (000)				None		
		0 17. Father's Name (First, Middle, Las	t)	1 1	lone		18. Mother:	s Name (F	First, Middle, I		me)	
a		14 0					16	4-D	1.1			
F	0	Marvin Austin 19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address	(Street ar	Lisa Number			, City or Town	, State, 2	Zip Code)
		Lisa Austin			30 Marie							
	ŀ	20a. Method of Disposition		20b. Place of I	Disposition (Nam	ne of		Dat		20c. Location		Town, State
		1 Burial 2 Cremation 3		θ	crematory or oth		1	L 1E	2005	Do 1 to vit	11. 1	han Ivaah
		 4 ☐ Donation 5 ☐ Other (Special Service Lice 21. Signature of Fundamental Service Lice 		Chesapea	ke Cremate			spc 13	, 2005	Beltsvi	116, 1	arylanu
once		XIII	Coulle					7604	C 1 C			. 1 MD 20
	+	23a. Party Enter the disease, or cor	nolications that cause	ed the death. Do no							d. Lat	urel, MD 20 Approximate
		shock, or heart failure. List only Immediate Cause (Final	y one cause on each	line.		, ,						Interval Betwee Onset and Dea
ın al		disease or condition resulting in death)	- u	an System F								3 Weeks
r			,	s a consequence of iia with Met	•	i dooi					ĺ	4 Weeks
,	in in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D	s a consequence of		10051	5					4 WEEKS
m.		Cause (Disease or injury	Immunosu	ppression a	fter Card	iac T	ranspla	nt				7 Weeks
Fyamina	Xa	that initiated events resulting in death) Last	C	s a consequence of								
	cal	(_d Congenit	al Cardiomy	opathy							20 Months
100	ed									1		
N/ c.	Pnysician/med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy 2 Petel death	3 □Ectopic pre	ednancy.					ate of del	
100	100	in the past 12 months? 1 ☐ Yes 2 ☑ No		at time of death	5 ☐ Other (spe					М	onth	Day Year
by d	nys.	9 Unknown	9LI UNKNOWN									
	S	Part II. Other significant conditions	contributing to death	but not resulting in	the underlying ca	ause giver	n în Part I.		23e. Did tot	oacco use cor		the cause of death
									1 □ Y€	es 2 No	3 □ Pr	obably 4 ⊡Unkr
o ic	ble								24a. Was a autops		Were au	topsy findings avail
	E								perform		death? 1 ☐ Yes	
8							26. Place o	f Death (0	Check only on			
	o o	25. Was case referred to medical	Laterated	tient 2 ER/Outp	patient 3 DO/	A Other	· 4 🗆 Nurs	ing Home	5 Reside	ence 6 🗆 Ot	her (Spec	cify)
a a	o De	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 k Inpa	1 X inpatient 2 E-Poutpatient 3 DOA 4 Nursing Home 5 Hesidence 6 Une								
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TO Bo	lo Be	examiner? 1 ☐ Yes 2 ☑ No	28a. Date of In (Month, E	jury 28b. Ti ay Year) Inj	me of 28 ury M	8c. Injury a Work? 1 □ Ye	es 2 □No					
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Cortification: To Be	Certification; 10 Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigating investigating determined 3 Suicide 6 Could not determined	28a. Date of In (Month, Don be 28e. Place of I	njury - At home, farretc. (Specify) st of my knowledge, of examination and	M n. street, factory, death occurred a	1 ☐ Ye , office at the time	es 2 No	28f	City or Town	ause(s) and m	anner as	stated.
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odical Cartification: To Be	edical Certification; 10 be	examiner? 1	28a. Date of In (Month, E) 28a. Place of I building, 28e. Place of I building, 28e. Place of I building,	njury - At home, farretc. (Specify) st of my knowledge, of examination and	M n, street, factory, death occurred a for investigation,	1 TYe	es 2 No	28f	City or Town d due to the ca at the time, di	ause(s) and mate and place,	nanner as , and due ed (Monti	stated. to the cause(s) h. Day, Year)
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odical Cartification: To Be	edical Certification; 10 be	examiner? 1	28a. Date of In (Month, E) 28a. Place of I building, 28b. Place of I building, 2b. Place of I buil	njury - At home, famelic. (Specify) st of my knowledge, of examination and stated. death (Item 23a) (T	M n, street, factory, death occurred a for investigation, 29c. Re	1 Ye , office at the time in my opi License es = 0	es 2 No	28f	City or Town d due to the ca at the time, di	ause(s) and mate and place,	nanner as , and due ed (Monti	stated. to the cause(s)

		-	For State Registrar	State of Maryla	•	nent of Health cate of Death		tal Hygien	711115	30428	
	Physicia /Medic Examin	al er	4a. Facility Name (If not institution, give The Johns Hop 5. Social Security Number 6. S	DRICK estreet and number) Cins Hospi ex 7. Age (In y	tal &b. &B. (St. last birthday) If L. Moi	OERSON City, Town, or Location WHMORE Inder 1 Year If Under this Days Hours	of Death.	Date of Birth	c. County of Dea BALTIMOR	E thplace (State or Foreign	
	Director motified at		384-22-5651	10c.	Yrs. City, Town or Location)	Ju	NE 13, 1	1927 MI	10d. Inside City Limits	
death with the Maryland	ns 23e or 28a-f cust be notifi	Direc	VA FAIRFAX 10e. Street and Number 7716 GROMWELL CT. 11. Marital Status	12. Was Decedent Ever in	13. Was (f. Zip Code 2152 Decedent of Hispanic O	Origin? (Specify	USA Yes or No-	14. Race - Am	encen Indian,	
21215-0036 de within 72 hours after o	urel', or ite	þ	1 Never Married 2 Married 3 Widowed 4 Divorced 15 Decedent's Ec (Specify only highest gra	Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: API de completed)	R 1972	specify Cuban, Mexica es 2 No Specify Usual Occupation of work done during mo	y:		Black, Whi Specify: WH Kind of Business	ITE	
	Hygiene, other then ent, the Me	Be Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+) 4	`life. DO N	OT use retired) ARY OFFICER 18. Moth	her's Name (Fir	st, Middle, Maide	S. AIR	FORCE	
b, Maryland	lith and Men 27 is marke r treumatic	2	NORMAN G. ANDERSOI 19a. Informant's Name/Relationship (MARY G. ANDERSON)	Type, Print) / WIFE	7716 GRC	dress (Street and Number	SPRINGF	ute Number, City	22152		
Baltimore,	Department of Hea Important: If item eny injury or othe		20a. Method of Disposition 1 Burial 2 Termation 3 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licer	Removal from State		or other place)	ility DEMAI	2005 FA	RAL CHAP	RCH, VA EL	
E	nysiclan Medical xaminer	Iner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	plications that caused the done cause on each line. a. SEPSI Due to (or as a constitution of the constitu	eath. Do not enter the					Approximate Interval Between Onset and Death 7 DAYS	
Box 68760, department of the contilicate baseveded	sys er	/Medical Examin	Cause (Uisease or influif) that initiated events resulting in death) Last	c. Due to (or as a const. d					23d. Date of de	livery	
		Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3 □Ecto	pic pregnancy er (specify)		Month Day			
_	has been sign je 2 should be	Completed by F	Part II. Other significant conditions o	ontributing to death but not	resulting in the underly	ing cause given in Part			2 ANo 3 □ P 24b. Were a prior to death?	o the cause of death? robably 4 Unknown utopsy findings available completion of cause of	
Division of Vital Records,	fter death. Director: After this certific in by the funeral director,	Certification; To Be C	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year	At home, farm, street, fa	DOA Other: 4 N 28c. Injury at Work? 1 Yes 2	28d.	5 ☐ Residence Describe how inju	ury occurred and Number or R	ural Route Number,	
]	within 24 hours a To the Funerel C completely filled	Medical Ce	(Check only 2 ☐ Medical Examone)	ysician: To the best of my niner: On the basis of exam and manner stated.		ation, in my opinion, de	eath occurred at	the time, date ar	nd place, and due	e to the cause(s)	
ToT	To:	Z.	29b. Signature and title of certifier Remeth C 30. Name and address of person who			29c. License number			ate signed (Moni	th, Day, Year) R 16,2005	
:	Sta	te	KENNETH C. B 31. Date filed (Month, Day, Year)	ILCHICK C	ARNEGIE 5	68 600 N	ORTH WOL	-FE STREET	BALTIMOR	E MARYLAND 2128	

			1 - For State Registrar	State of Marylan	d / Departr <i>Certifi</i>	ment of Health an icate of Death		jien 2005	30429
·	® Dhuaisi		Decedent's Name (First, Middle, Last	0	(1		2. Date of Dea		3. Time of Death
, E	Physici /Medic		Frederick		recht	•	Septem	bor 18,200:	J
	Examir Funeral Director	er	4a. Facility Name (If not institution, give MAULAND CENEY 5. Social Security Number 6. Se 212-42-7040	y Haspital	last birthday) If	City, Town, or Location of C Under 1 Year If Under 24 onths Days Hours	ta	4c. County of Dea	thplace (State or Foreign ountry)
	Q		Usual Residence of Decedent				1 00	10 1/141	CYLAND
	arylar	20	10a. State 10b. County		y, Town or Location				10d. Inside City Limits 1 □ Yes 2 No
	the M	Funeral Director	10e, Street and Number	OPE		CM MORE		0g. Citizen of What C	
	3a or	0	1004 Thomas	a Rlvd.		21221		USA	,
	mms 2	nere	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was	Decedent of Hispanic Origin s, specify Cuban, Mexican, P	? (Specify Yes or No-	14. Race - Ame Black, Whi	
36	or ftu		1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give	10	10		Specify: j	h. b
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or frams 23a or 28s-f ahow ha Madigal Examinar must be notified at	Completed by	15. Decedent's Edu	Year or Dates:	16a. Decedent	s Usual Occupation		16b. Kind of Business	/Industry
215	thin 7; en "na	nple	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give kind life. DO f	of work done during most of NOT use retired)	f working		
	filed with Hygiene. other the		17. Father's Name (First, Middle, Last)		UNen	ployed	Name (Eirst, Middle,	/U/ /	
Maryland	ed tal	To Be	Poher+ P. All	weight so		Mar	Marine (25), Milouie,	hite.	
ary	2 should and Men is marke eumatic	-	19a. Informant's Name/Relationship (T)	pe, Print)	19b. Mailing Ad	ddress (Street and Number of	Rural Route Number	, City or Town, State,	Zip Code)
	1 and 2 Health a tem 27 is		Mary Jane Heato	n-Sister	1835	Steven DR.	Cagewa	od MO S	01040
Baltimore,	Pages 1 nent of H int: if Itel		20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	face of Disposition emetery, cremato	ou or other place)		20c. Location - City or	
Itin			4 ☐ Donation 5 ☐ Other (Specify) 21. Signatuse of Funeral Service Ligens		DFU NER!	me and Address of Facility	-20-05 J	OPEST HIL	1110
Ba	permit. Departr Importe sny Inju		Humberly 1.	Savrotau	PEAC	CEFULALTERIU	ATIVES FUNE	RAICE REI	MATION CTR
dis.			23a. Part1. Enter the disease, or composhock, or heart failure/ List only of	cations that caused the death	n. Do not enter th				Approximate Interval Between
	Physician		Immediate Cause (Final / disease or condition resulting in death)	neumonia	a				Onset and Death
Q.	/Medical Examiner		1	Due to (or as a consequ	uence of):				
	3 -	ner	S quentially list conditions. if any, leading to immediate	Due to (or as a consequ	uence of):				
(and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	2					
58760,	cate be executed physicien and the burial-transit	al E	Tooling in county 2001	Due to (or as a consequ	dence or):				
	ifficate g phys as the	edical							
Box	death certific ne attending p ed for use as	Physician/Me	in the past 12 months?	3c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ecto	opic pregnancy er (specify)	23d. Date of de Month	23d. Date of delivery Month Day Year	
P.0	that the de led by the detached		9 Unknown Part II. Other significant conditions con		ulting in the under	ving cause given in Part I	23e. Did tol	pacco use contribute to	the cause of death?
Records,	The law requires that the sie has been signed by the page 2 should be detache	eted by				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			robably 4 Denknown
I Rec		Completed					24a. Was a autops perform	y prior to death?	utopsy findings available completion of cause of
Vital	Physiclan: Th this certificeteral director, pag	Be	25. Was case referred to medical examiner?	lospital:			Death Check only on	**	
o	Phys or this seal di	7: To	1 Tyes 2 VNo 27. Manner of Death	1 V npatient 2 1 28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury at Work?	ng Home 5 Reside	once 6 Other (Spe ow injury occurred	city)
ion	nding I ath. r: After e funer	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury N				
Division	To the Hospitel or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, f	actory, office	28f. Location (St City or Town	reet and Number or Ru n, State)	ural Route Number,
П	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in		29a. Certifier 1 Certifying Phys	sician: To the best of my know	wledge, death occ	urred at the time, date and p	lace, and due to the ca	tuse(s) and manner as	s stated.
	he Ho n 24 h ha Fui pletely	edical	(Check only 2 Medical Exami	ner: On the basis of examinet and manner stated.	ion and/or investig	gation, in my opinion, death o	occurred at the time, d	ate and place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. License number	2	9d. Date signed (Mont	h. Day, Year)
,	10		() 5	m . m	,D	127217		7-18-6	70
	7)		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, Print	roman Hac	Ottol		
2	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signal	rure Angelia	103			,
M.	Registr	ar	SEP 2 0 2005	ARMISA LO	A STATE OF THE STA				

			1 - For State Registrar	State of Maryla	nd / Depa	artment of H	lealth and Death	Mental Hygi	ene 00	5 30430	
. Da 4	Physici /Medio		1. Decedent's Name (First, Middle, Last) Mary Marie	Anderson				2. Date of Death Month September	Day Y	3. Time of Death ear 1538 M	
	Examir		4a. Facility Name (If not institution, give s Union Memorial Ho			4b. City, Town, or Baltimor	e.			Dealh N/A	
N.	Funeral Director		5. Social Security Number 6. Sex 132-09-4958	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Min		Year) 9 1914 1	Birthplace (State or Foreign Country) Pennsylvania	
	Maryland f ehow	lor	10a. State 10b. County Md . N/A		ity, Town or Lo					10d. Inside City Limits 1 🏿 Yes 2 🗆 No	
	with the	Il Director	10e. Street and Number 609 East 38th St	reet		10f. Zip Code 21218		10	g. Citizen of Wha	at Country?	
386	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "neturel", or Itams 23e or 28e-f ehow wart liquty or other traumatic event, the Medical Expiritms must be rotified at ODGE.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	2. Was Decedent Ever in the Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (n, Mexican, Pue Specify:	(Specify Yes or No- arto Rican, etc.)		American Indian, White, etc. White	
Maryland 21215-0036	l within 72 hou lene. r than "neture the Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of w	orking	6b. Kind of Busin	·	
/land 2	uld be filed Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, Last) Wasyl Labowski				18. Mother's Na Yrist	ame (First, Middle, M ina Muta			
, Mary	and 2 sho salth and ! n 27 ie ma er traume	7	19a. Informani's Name/Relationship <i>(Typ</i> Mr. Walter J. Ander		4/	-		Rural Route Number, Cockeysvil			
Baltimore,	Pages 1. nent of He ant: If Iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemetery, cren	sition (Name of natory or other plac rk Cemete			Oc. Location - Cit Baltimor		
Balt	permit. Departitimport. eny Inj		21. Signature of Funeral Service License	3	22	Name and Address Ruck Tow 1050 Yor	s of Facility SON FUN k Rd. T	eral Home, owson, Md.	Inc. 21204		
de.	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	eations that caused the deale cause on each line. Due to for as a conse	th. Do not ente	er the mode of dying	g, such as cardio	ac or respiratory arres	st,	Approximate Interval Between Onset and Death	
0,	death certificate be executed as e attending physician and ad for use as the burial-transit	Examiner	Sequentially list conditions, If any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c.	Due to (or as a conse							
68760,	rtificate by ng physici as the bu	Aedical	d.			U780					
.O. Box	that the death certific led by the attending p detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	at death 3	Ectopic pregnancy Other (specify)			23d. Dale of Month	23d. Date of delivery Month Day Year	
٥.	The law requires that the tee has been signed by thoage 2 should be detached.	ρ	Part II. Other significant conditions cont	inbuting to death but not re	sulting in the ur	nderlying cause give	on in Part I.			te to the cause of death? Probably 4 Munknown	
Division of Vital Records,		Completed						24a. Was an autopsy performe	prior deat		
<u> </u>	ysiclan: Th s certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	ER/Outpatien	I 3□ DOA Othe	_	eath Check only one Home 5 Residen	ce 6 Other (Specify)	
ion of	Attending Physiclan: or death. sector: After this certification in the funeral director. It	atlon: T	27. Manner of Death 1 DNatural 5 ☐ Pending 2 ☐ Accidenl investigation	28a. Dale of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 🗀		28d. Describe how			
Divis	tal or Attenders after death al Director: ed in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al h building, etc. (Speci	ome, farm, stre fy)	eet, factory, office		28f. Location (Stre City or Town,		r Rural Route Number,	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier	er: On the best of my known: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the timestigation, in my op	e, date and place inion, death occ	e, and due to the cau curred at the time, dat	ise(s) and manne e and place, and	r as stated. due to the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	- 000		29c. License			d. Date signed (M		
, I	A		30. Name and address of person who con	npleted cause of death (Iter	m 23a) (Type, l		61310	3	eptembe	r 18, 2005	
()		Rafik Hunna 31. Date filed (Month, Day, Year)	Union M 32. Registrar's Signa	emori	al Ho	spital	Balt	imore	, MD	
	Sta Registr	_	SEP 2 0 2005	And an A	3 Parch	12 12					

		=	1 - For State Registrar	tate of Maryland	/ Depa	artment of H rtificate of L	lealth and I Death	Mental Hyو ۴	gien 2 0 0 5	30431	
	Physici /Medic		1. Decedent's Name (First, Middle, Last)			Bare for	ot	2. Date of Dea Month Septen	ıth _		
	Examin Funeral Director		4a. Facility Name (If not institution, give street Inc Johns Hop Kines 5. Social Security Number 6. Sex 1 M	Hospital		Balting If Under 1 Year Months Days	Location of Death OFE C1 If Under 24 Hrs. Hours Min.	B. Date of Birt (Month, Da) APRIL 1	N/A N/A N/Year)		
	and we		Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	Town or Lo	cation				10d. Inside City Limits	
	Maryl I sho	tor	MARYLAND N/A		BALT1	MORE				1 X Yes 2 □ No	
	th the	Jirec	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?	
	s 23a	rail	2037 JEFFERSON STE		40.1	212:		'/ - \/ N N	U.S.A.		
336	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show diest Examiner must be notified at	by Funerai Director	1 Never Married 2 Married	Vas Decedent Ever in U.S. Armed Forces? ☐ Yes 2 ☑ No f Yes, Give fear or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2 🏿 No	Specify:	реслу Yes or No- o Rican, etc.)	Specify:	merican Indian, hite, etc. BLACK	
21215-0036	_⊆	Completed by	15. Decedent's Education (Specify only highest grade contentary/Secondary (0-12)	on mpleted) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o OO NOT use retired	during most of wor	king		6b. Kind of Business/Industry	
	e filed with Il Hygiene. other thar vant, It e M		unknown 17. Father's Name (First, Middle, Last)		PUBI	IC WORKS			GOVERNMI Maiden Surname)	ENT	
Maryland	ould be fi Mental H arked ot atic ever	To Be	POODLE FAUST				ETTA C		waiden Sumame)		
ary	2 should be and Mental is marked of aumatic ev	۲	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	ng Address (Street a			r, City or Town, State	e, Zip Code)	
	5 5 5 E		Etta Jones/Mother	OOL Di-	-	ORLEANS sition (Name of	STREET,		RE, MARYLA		
101		1 8	20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Remo	val from State	netery, crer	natory or other plac		Date	20c. Location - City		
Baltimore,	permit. Page Department of Important: if any injury or once.		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	/ MT Z	22	EMETERY I. Name and Addres ILLIAM C I	ss of Facility		LANSDOWNE, FUNERAL HO		
	* =		23. Part . Enter the disease, or complicating the control of the c	ons that caused the death.		er the mode of dying			rest,	Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequer	nce of):	ath				one hour	
ı	Examiner		Sequentially list conditions b. —	Cereb	~ va	scular 1	Acaden	X		one hour	
_	ed self	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nce of):							
68760,	icate be executed physician and s the burial-transit	edical Examiner									
Box 68	. <u>≡</u>		23b. was decedent pregnant	f yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de		Ectopic pregnancy			23d. Date of o		
P.O. B	the d	Physician/M	1 Yes 2 X No	4 Pregnant at time of deat		Other (specify)			Month	Day Year	
	law requires that as been signed b 2 should be deta	by	Part II. Other significant conditions contrib	uting to death but not resulting	ng in the ui	nderlying cause give	en in Part I.	23e. Did to	2.4	to the cause of death? Probably 4 Unknown	
Division of Vital Records,	The la ate has page 2	Completed			·	 		24a. Was a autop perfor 1 ☐ Yes	sy prior t		
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ital:		Otho		th (Check only or	18)		
of	Physic r this or and dire	: To	To tes ZANO	8a. Date of Injury 28	VOutpatien Bb. Time of	28c. Injury	4 □ Nursing H		ence 6 Other (Spow injury occurred	Decify)	
ion	Attending Isr death. actor: After by the funer	atior	1. Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work	k? Yes 2 □ No				
Divis	al or Attenos after deatl	Certification;	3 Suicide 6 Could not be 4 Homicide determined 2	Be. Place of Injury - At home building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Diractor: After this certific completely filled in by the funeral director.	Medical ((Check only 2 Medical Examiner:	n: To the best of my knowle On the basis of examination and manner stated.	edge, death n and/or inv	n occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	, and due to the c rred at the time, d	ause(s) and manner late and place, and d	as stated. ue to the cause(s)	
	To the twithin 2 To the F	Σ	29b. Signature and title of certifier			29c. License			29d. Date signed (Mo	onth, Day, Year)	
,	50 i		mulis H	L, MU	2-1 (7		52499		09/14/05		
	4		Mark T Hunbac	eted cluse of death (Item 23	Caro	line Stra	ret Ba	Himor	e MD2	1287-0941	
	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 0 200	32. Rogistrar's Signatur		Carte	<u> </u>				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) -13,2005 **Physician** Ruth Ellen Barrett /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Maryland Greneral Hospita Baltimore N/A If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Hours Months Days Min Yrs 14, 1932 215-28-4931 Maryland Director Usual Residence of Decedent with the Maryland ^{10a. State} Maryland 10c. City, Town or Location Glen Burnie 10d. Inside City Limits 10b. County Anne Arundle the Medical Examiner must be notified at 1 ☐ Yes 2 ▼No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 21061 238 212 Roosevelt Ave. U. S. A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ♥ No Specify: White þ 3 XWidowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) important: If item 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mertal Otto Curry Emma Smoot 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 Roosevelt Ave. Glen Burnie, MD. <u> William L. Kato, son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition
1 ☐ Buriał 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Department of 5 Bayview Crematory 09-15-05 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 21. Signature of Funeral Service Licensee any ir Roken G 2719 Hammonds Fry Rd. Lansdowne, MD. 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Preumonia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospitel or Attending Physician: The law requires that the death certificate be executed Stage Due to (or as a consequence of) O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 ☐ Unknown Division of Vital Records, P. Part II., Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? nyo cardial 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral i 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 entifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier seath (Item 23a) (Type, Print) Maryland General Hospital <1ddu poul, mil. nunaminea 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 18, September Rosalie L. Biddison 2005 2:15 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Genesis Health Care Anne Arundel Brooklyn If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 1 (M8nth 1 924 4 ear) Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖾 F 218-14-0008 81 Maryland Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.
Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral', or Items 23a or 28a-f shov Examinar must be notified at MD Baltimore Baltimore Highlands 1 ☐ Yes 2 ☑ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2817 Delaware Ave. 21227 U.S.A. Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married 1 Yes 2000 Specify: White Specify: If Yes, Give Year or Dates: Completed by 3[™] Widowed 4 Divorced The Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Clerical Work unknown 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Howard Levering perriit. Pages 1 and 2 should be Department of Heath and Mental Important: If item 27 is marked of any injury or other traumatic eve Anna Winters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Finizza/Niece 3009 New York Ave. Baltimore MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 □Removal from State Holy Cross Cemetery 9-20-2005 * 4 □ Donation 5 □ Other (Specify) Brooklyn, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD 21227 23a. Part1: Enter the disease, or of mplications that cause if the death. D to other the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Live nly one cause on each limbs. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FAILURE Physician /Medical Due to (or as a consequence of): CARDIOVARCULAR Examiner ALTERIOSCIEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, 🔏 been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ IRINAUY 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? page 2 this certificate 1 ☐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3☐ DOA Certification: To 28c. Injury at Work? funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death. investigation 2 Accident completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C

State Registrar

Medicai

29a. Certifier

(Check only one)

surea

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 2005



3001

1 Scrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CLA CA MININA MININA MININA MININA MININA SCREEN ST. SACTIMORE MININA SCREEN

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

21776

29d. Date signed (Month, Day, Year)

SEPTEMBER 19, 2007

State of Maryland / Department of Health and Mental Hygienes Reg. No. 2005 30434 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Betty Jane Bollinger Sept. 9:50 p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3377 York St. Manchester Carroll If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 210-12-848 1 □ M 2 □ F 81 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Evanting Trust by neutring an once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Maryland Carroll Manchester 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 3377 York St. 21102 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☑-Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ira Braun Lula Wolf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5722 St. Albans Way, Baltimore, Md. 21212 Sandra Zeiler - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Lutheran Cem. Sept. 21,2005 Manchester, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BCkhardt filmeral 3296 Charmil Dr. Chapel P.A. Manchester, Md. 21102 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Priysician - 5 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certiticate be executed use as the burial-tran ding physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) signed by the al 1 Yes 2 Soo Part II, Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 2 ☐ O 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Carcinom 1□ Yes →No or Attending Physician: the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital: 1 Yes 2500 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide To the Hospitei **Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Novem D23443 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAYOW VAYOLA 1130 /3 a (HMOYE) BIVE Westminster MD 21157 0 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SET 2 U LUUS Registrar

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/Medica	_	a. Facility Name (If not institution, give	street and number)	4	4b. City, Town, o		of Death		c. County	of Death	
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Funeral Director			M 2□F	81 Yrs.	Months Days	Hours	Min. May	of Birth th, Day, Yea 14, 1	924	Nort	h Carolina
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23a or	D	3115 Thornfield Ro	ad		212	207			U	JSA	
or Items	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1X Yes 2 1 If Yes, Give Year or Dates:	Ever in U.S. 13. 1943 1943	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	dispanic Origan, Mexican Specify:	gin? (Specify Yes i, Puerto Rican, e	or No-	Blac	- Americk, White,	_
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sician edical		Immediate Cause (Final disease or condition resulting in death)	SEI		MIA						
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hed for use	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у			23d. Dat Mor	e of deliv	ery Day Year
pe del	by Ph	Part II. Other significant conditions co	ntributing to death b	ut not resulting in the	underlying cause giv	ven in Part I	. 236	. Did tobacco		ibute to t	he cause of death?
should b	eted						24a	. Was an	24b. V	Vere auto	opsy findings available
2 2	Completed							autopsy performed? Yes 2	5	rior to co leath?	ompletion of cause of 2 No
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5		30. Name and address of person who o	completed cause of	Seath (Item 23a) (Type	Print)	E COU	ips Ho	OSPIT	FL		
Cho	te	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	3						
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			for State Registrar	State of Maryla	•	artment of H		ental Hygie	7005	30436
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	Director		220-40-8471 Usual Residence of Decedent	91				March 19	, 1914 Oh	io
	arylan show		10a. State 10b. County	10c.	City, Town or Lo	ocation			1	1 ☐ Yes 2 ☑ No
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	o the ithin 2 o the omple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number	29d.	Date signed (Month,	Day, Year)
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	5		30. Name and address of person who	completed cause of death (I	Item 23a) (Type		- R. 12	1.0	/211	
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5.0	- Funeral Director		5. Social Security Number 6. Sex 213 46 3761	7. Age (In yrs.	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Dec. 17	Year) 9. 1944 M	Birthplace (State or Foreign Country) aryland
	pug *		Usual Residence of Decedent 10a, State 10b, County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
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Baltimore,	permit. Pages 1 and 2 Depertment of Health a important: if item 27 ti any injury or other tra once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	20b.	Place of Disportant Compterly, cren	sition (Name of natory or other place			20c. Location - City	
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Division of Vital Records,	if or Atten after deet Director: d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At the building, etc. (Special		eet, factory, office		28f. Location (St City or Town		r Rural Route Number,
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)	with.	Σ	29b. Signature and title of certifier	MD		29c. Licens	e number G72		9d. Date signed (M	fonth, Day, Year)
2	9		30. Name and address of person who con	ompleted cause of death (fte	om 23a) (Type	Print)	+ Balt	inco W	10 212	01
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/ Exar		-	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of I	Death
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Funer Direct			5. Social Security Number 6. S 213–18–6601 1 Usual Residence of Decedent	ex /. Age	e (In yrs. last birtho	Months Days	Hours Min.	8. Date of Birth (Month, Day, 5-2-192		Birthplace (State or Foreign Country)
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3a or	1	ב	290 Riverside Dr	ive		21122			U.S.A.	
inc, INION y IONION 2 INC. INC. ON Solution of 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. If health and Mental Hygiene. Item 27 is marked other than "natural," or Items 23a or 28e-f ehow other treamstic event, the Medical Examination be notified at	1	by runeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ XWidowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race -	American Indian, White, etc. White
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filed with Hygiene. Ather ther		E	Elementary/Secondary (0-12)	College (1-40) 3		come Tax Di	vision		State of	f Maryland
al Hys		D C	17. Father's Name (First, Middle, Last,				18. Mother's Name	e (First, Middle, M	aiden Sumame)	
should be ind Mental marked o		0	Paul J. Reed, Sr					A. Silbe		
2 sho and and lis my	14	1	19a. Informant's Name/Relationship (-		Mailing Address (Street				
t and the alth mm 27		-	Mrs. Marie B. Cra	andall/Dau		30 Magothy			.ena, MD Oc. Location - Cit	
Page nent o			1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 📉 Other (Specif	Removal from State	1		9-16-	2005	Baltimor	re, MD
permit. Departr Import	once.	1	21. Signature of Funeral Service Licer	anur	M01357	22. Name and Addres	ss of Facility Sin Ave SW; G			
Physicia /Medic Examin	al		23a. Part1. Englished disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. OY	the death. Do no ne. Office of the death. Do no ne. a consequence of	y arte	ng, such as cardiac	or respiratory arre	st.	Approximate Interval Between Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. 1	a consequence of)	tes	.XUX	naccor		
cate be physicial the bu		edical		d						
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely tilled in by the Innertal director, page 2 should be detached for use as the burial-transit		Pnysician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2.4 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) □	,		23d. Date o Month	of delivery Day Year
equires that sen signed by yould be deta		2	Part II. Other significant conditions of	ontributing to death b	ut not resulting in t	he underlying cause giv	en in Part I.	23e. Did toba		ite to the cause of death? Probably 4 Unknown
The law recate has bee page 2 short		Completed						24a. Was an autopsy perform	ed? prio	re autopsy findings available r to completion of cause of th? Yes 2 \(\subseteq \text{No} \)
cien: ertific ector,		ge	25. Was case referred to medical examiner?	Lle onitel:			26. Place of Death	(Check only one)	
Physi this c	1	9	1 ☐ Yes 2 🕱 No 27. Manner of Death	Hospital:			4 Nuising Ho	me 5 Resider 28d. Describe how	nce 6 Other (Specify)
After funer			1 Natural 5 Pending	28a. Date of Inju (Month, Da	y Year) Inji	ury Wo	rk? Yes 2 □No	200. 20001100 1101	w injury occurred	
or Atten after deat Director:		Certification;	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e Zoo Blace of Ini	ury - At home, farm c. (Specify)	n, street, factory, office		28f. Location (Str. City or Town,		or Rural Route Number,
Hospita 24 hours Funeral		Medical			f examination and/	death occurred at the til or investigation, in my d				
To the		Ne Ne	29b. Signature and title of certifier	Easl	lym	29c. Licens	56741	29	d. Date signed (A	Month, Day, Year)
\	0		Name and address of person who	completed cause of d	leath (ten 23a)	y e, Print)	Beach R	Ed. PASA	dena	md 21122
	Stat istra		31. Date filed (Month, Day, Year) SEP 2 0 200		ar's Signature	seli				

	•	State of Maryland / Department of Health and N 1 - State Registrar Certificate of Death	Mental Hygie Reg	Z U U 5	30439
Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year	3. Time of Death
/Medic	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	09	Pay 2000 4c. County of Deat	•
Examin	ier	HOWARD COUNTY GENERAL HOSPITAL COLUMBIA		HOWAR	D
Funeral Director		5. Social Security Number 6. Sex 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Min.	8. Date of Birth (Month, Day, Y		nplace (State or Foreign untry)
		Usual Residence of Decedent	May 17, 1	1918 Min	nesota 10d. Inside City Limits
Marylan 1 show ied at	ō				1 X Yes 2 □ No
ith the M or 28e-1	Director	Minnesota Goodhue Wanamingo 10e. Street and Number 10f. Zip Code	10g	. Citizen of What Co	untry?
e 23a		698 Sandy Court 55983 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	pecify Vas of No-	U.S.A	
at the Maryland settled with the Maryland be filed within 72 hours efter death with the Maryland Hygiene. The Hygiene do ther then "netural", or items 23a or 28e-f show event, I.e. Marylast Examiner must be molified at	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Sp. fif Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White	
thin 72 hours e. en "netural", Madical Exa	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	sing 16	b. Kind of Business/	ndustry
filled wi Hygien ther th		8 Custodian 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Ma	Public Sc	hools
a a b	o Be		Signora	Rolland	
2 should be and be is maintained.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run	ral Route Number, C	city or Town, State, Z	ip Code)
Health Health tem 27 other tr				nescta 55 c. Location - City or	
Pages nent of l ant: if its ury or o		1 Aburiai 2 Cremation 3 Hemoval from State	-2005 Z	umbrota,	Minnesota
permit. Pages 1 and 2 should pearmit. Pages 1 and 2 should Department of Health and Men Important: if item 27 is marke eny injury or other treumatic. Once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman F 7250 Washington B	uneral Ho lvd., Elk	me at MMP ridge, MD	, INC.
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arrest	22.7	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) ATRIAL JIBRILLATION Due to (or as a consequence of):			
Examiner		Sequentially list conditions, b. YENTRICULAR TACHYCARDIA			
) ted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiate events	S		
cate be executed physicien and the burial-transit	Еха	that initiated events resulting in death) Last C. The Local Last Due to (or as a consequence of):			
icate by physic s the bo	dicai	d			
The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23d. Date of deli Month	very Day Year
that the denoted by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
w requires that been signed to should be det	ted by	ABDOMINAL AORTIC ANEURYSM	1 ☐ Yes	2 No 3 Pro	bably 4 Winknown
The law rate has be page 2 sh	Completed		24a. Was an autopsy performe 1 \(\text{Yes} \) 2	d? prior to death?	opsy findings available ompletion of cause of 2 No
Physician: The this certificate hir all director, page	Be	examiner? Hospital: Other	th (Check only one)	G TOther (Con-	4.0
g Physicar this	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how		ny)
r Attending P or death. rector: After t by the funera	catio	2 Accident investigation M 1 Yes 2 No	29f Location (Stron	et and Number or Ru	m I Pouto Number
after of in by	Certification:	3 ☐ Studio determined determined determined determined determined building, etc. (Specify)	City or Town, S	State)	ar noute Number,
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,	edicai C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.			
To th withir To th comp	Me	29b. Signature and title of certifier 29c. License number D0058580	29d	Date signed (Month	
\bigcap		(1.10)		/1101	
9		BAI KANH, M.D. 3233 SUPERIOR LN, B 21. BOWIE, MD 20	0715.		
Sta Registr		SEP 2 0 2005			

			For State Registrar	State of Maryl		artmer			Mental Hy	ygiene Reg. No. 2	05	301	440
- 9	Physici		Decedent's Name (First, Middle, Last DONALD	")	F	BISCAF	RR		2. Date of D Month SEPTEN	MBER 15,	Year 2005	3. Time o	
1 1	/Medio Examir		4a. Facility Name (If not institution, give STELLA MARIS HOS					Location of Death	ı IM	4c. Coun	ty of Death		IMORE
	Funeral Director	-9lic	5. Social Security Number 6. Se 577 – 38 – 3347	TM 20 =	yrs. last birthday 4 Yrs.	Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D JAN. 12	orth (Pay, Year) 2,1931	9. Birthi	place (State ntry) D	or Foreign
	Maryland a-f ahow	ctor	10a. State 10b. County FL PALM BE		. City, Town or L	ocation	BEACH					10d. tnside 0	City Limits
	ath with the 23a or 28 unt be no	ral Director	10e. Street and Number 5061-D NESTING W				p Code	33484		10g. Citizen o	What Cou	usA	
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28e-f show important: If item 27 is marked other then "natural", or items 23e or 28e-f show hipty or other traumatic event, the Medical Examinar must be notified at once.	d by Funeral	11. Maritat Status 1 □ Never Married 2 ◯ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates:	OREA	Was Dece If Yes, spe 1 Yes		spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or N o Rican, etc.)	Io- 14. Re Bl	ace - Ameri ack, White, ify:		TE
21215-0036	d within 72 h giene. or then "netu the Medical	Completed	15. Decedent's Edu (Specify only highest grace Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+)	(Giv	DO NOT L	ork done d	turina most of woi	rking	16b. Kind of		dustry	
Maryland	lould be filed I Mental Hygi harked other hatic event, t	To Be C	17. Father's Name (First, Middle, Last) JACK		BISC	ARR		18. Mother's Nar	, .	e, Maiden Suma	ime)	FELDI	MAN
	1 and 2 sho Health and I tem 27 le ma		19a. Informant's Name/Relationship (7)	WIFE	5061	D NE	ESTIN	G WAY -	DELRAY	BEACH,	FL 33	484	
Baltimore,	mit. Pages 1 partment of H. cortant: If iter injury or oth		20a. Method of Disposition 1 🛱 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify,	Removal from State	KING DAY	ID WE	MUKI	ø) GARDENS AL ↓09/1	8/2005		CHUR	CH, V	A
Ball	permit. Departm Importa eny inju		21. Signature or Funeral Service License	· ·	8	3900 F	REIST	ERSTOWN	ROAD -	PIKESVI	_		
8760,	Certificate be exacuted had grant and a property of the purial-transit and the purial-trans	dical Examiner	23a. Pan./ Ent. the disease, or the short of the cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last	b. Cue to (or as a cord.) Due to (or as a cord.) Due to (or as a cord.)	L CANCE sequence of):							Interval Be Onset and	etween
.O. Box 68	death certifie attending	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pro 1 □ Live birth 2 □ i 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	⊒Ectopic p ⊒ Other (s				1	ate of deliver	,	Year
s, p	S C 90	þ	Part II. Other significant conditions co	entributing to death but not	resulting in the	underlying	cause give	en in Part I.	1	tobacco use co Yes 2 □ No		he cause of	
of Vital Record	The law ate has b page 2 sl	Completed	Of Wassess should be added			Design to			ped 1 🗆 Yes	opsy formed? 2 X No	. Were auto prior to co death? 1 Yes	ppsy findings mpletion of a 2 No	available cause of
sion of Vit	ding Phys h. After this funeral di	ation: To Be	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatie 28b. Time r) Injury		28c. Injury Work	4 Noising F	lome 5 Res	sidence 6 XIO how injury occu		v) HOSE	CICE
Division	ء ۾ ٿا ج	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (Sp	At home, farm, s pecify)	reet, factor	y, office			(Street and Nun own, State)	ber or Rura	il Route Nur	nber,
	the Hospitei in 24 hours a the Funerel i	edical	(Check only 2 Medical Exam	vsician: To the best of my iner: On the basis of examinant manner stated.		rvestigation	n, in my of	oinion, death occu		e, date and place	, and due to	the cause((s)
)	To the within 2 To the complet	₹.	29b. Signature and title of certifier			29	c. License	1372)		29d. Date sign	ed (Month, //5/c	Day, Year)	
	67		30. Name and address of person who c DR. TARIQ MAHMOO	D 2300 DUL	ANEY VAI		RD.	TIMONIUM	, MD 21	093	•		
	Sta Regist		31. Date filed (Month Day, Year) 20	32. Pegistrar's S	ignature	book	,						

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SEPTEMBER 15, 2005

DONALD BISCARR

			For State Registrer	te of Maryland / D	Depar <i>Cert</i>	tment of Heificate of L	ealth ai D <i>eath</i>	nd Menta	l Hygie _{Reg.}	^{ne} 2005	30442
			1. Decedent's Name (First, Middle, Last)					2. Date	of Death	Day Yeer	3. Time of Death
	Physicia /Medic		Marjorie F. Baciga	lupe					tember	•	3:27 P M
	Examin		4a. Facility Name (If not institution, give street a	and number)		4b. City, Town, or	Location of			4c. County of Deat	1
			Genesis Hamilton			Balti		411m		N/A	
	Funeral		5. Social Security Number 6. Sex 1	7. Age (In yrs. last birt		If Under 1 Year Months Days	Hours	Min. (Mo.	of Birth	ear) 9. Birth	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent	88					3/1917	Man Man	yland
	yland now		10a. State 10b. County	10c. City, Town	n or Loca	ation					10d. Inside City Limits
	- Man	ţ	MD N/A	Balti	imor	e					1 X Yes 2 □ No
	th the	ire	10e. Street and Number			10f. Zip Code			10g.	Citizen of What Co	untry?
	23e	Funeral Director	4003 Century Road		,		21206			U.S.A.	
	tems	une	An	s Decedent Ever in U.S. ned Forces?	13. W	as Decedent of His Yes, specify Cubar	spanic Origi n, Mexican,	in? (Specify Ye: Puerto Rican, e	s or No- itc.)	14. Race - Amer Black, White	
9	4 within 72 hours after death with the Maryland jiene. Then "neturel", or Items 23e or 28e-f show Ite Medical Evar. It within the tricitied at	by F	if S]Yes ŽŽ]No es, Give ar or Dates:	1[⊒Yes 2⊠XNo	Specify:			Specify: W	hite
215-0036	thous	edt	15. Decedent's Education	16a.	Decede	nt's Usual Occupa	ition		165	o. Kind of Business/l	
دا	nin 72	Completed	(Specify only highest grade comp	eleted)	(Give ki	nd of work done d O NOT use retired)	uring most (of working			.,
7	d with	Ë	8		Sales	s Clerk			S	tewarts D	ept. Store
פ	be filed stal Hygie of other event, II	Be	17. Father's Name (First, Middle, Last)					's Name (First,		den Sumame)	
<u>a</u>	Mer Mer arke	은	Major Stan Fletcher				E1	la McNe	al		
Maryland	O - 0 - 0		19a. Informant's Name/Relationship (Type, Pr.							ity or Town, State, Z	ip Code)
	s 1 and 3 Health item 27 other tr		Douglas Bradford/Cous 20a. Method of Disposition			Box 343 I		, Delaw		9940 Location - City or 1	Four State
ĕ	of i		1 ☐ Surial 2 ☐ Cremation 3 ☐ Remova	ii ii oiii State		tion (Name of atory or other place					
altimore,	permit. Page Department Importent: Il any injury o		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen se	Parkw		Cemetery		9/19/05		altimore,	
g	permit. Page Department of Importent: If any injury of once.		Xemen 5	largetter?	6/	415 Relat	r Roa	Miller-	Dippe	I Funeral Maryland	Home Inc.
			23a. Part1. Enter the disease, or complication	s that caused the death. Do n							Approximate
	Physician		shock, or heart failure. List only one cau- Immediate Cause (Final		0						Interval Between Onset and Death
	/Medical		resulting in death)	ASPIRATION Due to (or as a consequence of		UMONIA					
	Examiner			ENTESTIVAL	DB6	TRUCTIO	N				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of		,, , , , , , ,					
X	nd trans	Examiner	that initiated events								<u></u>
ģ	cate be executed physician and the burial-transit	Ë	resulting in death) cast	Oue to (or as a consequence of	of):						
8760,	cate t	dicai	d								
×	The law requires that the death certifi ste has been signed by the attending I age 2 should be detached for use as	Physician/Me	IF FEMALE: 23c. If y	es, outcome of pregnancy						23d. Date of deli	/ADV
Rox	leath atter i for u	ciar		Live birth 2 Fetal death Pregnant at time of death		ctopic pregnancy Other (specify)				Month	Day Year
o.	res that the de signed by the a l be detached f	hysi	9 ☐ Unknown 9E	Unknown							
J.	s that ned b e deta	by P	Part II. Other significant conditions contribution	ng to death but not resulting in	n the und	lerlying cause give	n in Part I.	236	. Did tobac	co use contribute to	the cause of death?
ğ	w require been sig should b		CEREBRO - VASCULA	R ACCIDE	NT				1 🗌 Yes	2 No 3 □ Pro	obabiy 4 ∐Unknown
Records,	e law re has bee je 2 sho	Completed						248	. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
_		E O						1	performed Yes 2	death?	
Vital	i cien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					of Death (Check	only one)		
<u>></u>	hysic his ce Il dire	으	1 ☐ Yes 2 No	1 Impatient 2 EH/Out		3□ DOA Othe	4 Nurs	-		e 6 □Other (Spec	ily)
Division of	ding Ph h. After th funeral	 	1 Vatural 5 ☐ Pending		Time of njury	28c. Injury Work	?		scribe how i	njury occurred	
<u>s</u>	tendi Jeath tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be	Disco of latings. At home to			′es 2 □ N		ation (Strace	t and Montage of Do	- 1 Co. de Ali mbo
₹	of or Attend after death Director: /	Certification:	4 Homicide determined 286	 Place of Injury - At home, far building, etc. (Specify) 	ırm, stree	et, factory, office			or Town, S	t end Number or Rui tate)	al Houte Number,
_	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.		29a. Certifier 1 Certifying Physician:	To the best of my knowledge	a. death	occurred at the time	e. date and	place, and due	to the cause	e(s) and manner as	stated.
	e Ho: 24 h e Fur	edicai	(Check only 2 Medical Examiner: O	n the basis of examination and d manner stated.	d/or inve	stigation, in my op	inion, death	occurred at the	time, date	and place, and due	to the cause(s)
	To th withir To th compl	Me	29b. Signature and title of certifier			29c. License				Date signed (Month	
			· augardona M	D		D	16619		Le	piember.	15,2005
	n		30. Name an addless of person who complete		(Туре, Р	rint)		/			15,2005
			C.VEROARA-SOARE	-0/-1//	RFO	RO RE). B+	WINOR	5 ME	0. 2/2/4	<u> </u>
	Sta Registr		31. Date filed (Month, Day, Year) SFP 2. 0. 2005	32. Registrar's Signature	R.	وظعه					
	9.0.		2 L L V 11 V 11 V 11 V 11 V 11 V 11 V 11	6 3 at 3 2 2	40.25	-					

State of Maryland / Department of Health and Mental Hygie e 0 5 30443 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Vear Madge T. Cramer 12:50 a^M /Medical September 17 2005 Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens Catonsville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 212-07-0208 1□M 2XF Days Hours Min. 96 Director March 28, 1909 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Mistical Examination at the national event. 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane HV512 21228 Funerai United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after rent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Š 3 XWidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George N. Tyler 2 Ella Phoebus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward L. Cramer / Son 33 Locust Drive, Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Denation 5 Other (Specify) Mt. Olive UMC Cem. 9/21/05 Randallstown, Maryland uneral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature ot 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 0000 disease or condition resulting in death) cars /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and I-transit certificate be executed the attending physician a Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. It yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached ☐Yes 2. ZNo 9☐Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy tindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2000) 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural 2 Accident 5 | Pending death. investigation within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. one) 29b. Signature and title of certifie 29c. License number UND 30. Name and addres of perform who completed cause of death (Item 23a) (Type, Print) Marde Nu 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of	f Maryland		artmen rtificate			and Me		giene Reg. No.	005	30444
			1. Decedent's Name (First, Middle, L	ast)							2. Date of Dea	ath		3. Time of Death
	Physici /Medio		Robert Leo C	lay							Month Septemb	Day Der l	Year L4 2005	8:10 P M
	Examir		4a. Facility Name (If not institution, gi	ve street and nun	nber)		4b. City,	Town, or	Location o	f Death		4c. (County of Death	
			Laurel Regional	Hospital	L			Laur	el			P	rince G	eorge's
	Funeral			Sex	7. Age (In yrs. la	st birthday)	If Under	1 Year	If Under 2	24 Hrs.	B. Date of Birth	_	0.00	
	Director		578-46-5022	MXM 2□F	68	Yrs.	Months	Days	Hours	Min.	100.20	19	936 Miss	issippi
	P .		Usual Residence of Decedent											
	show	_	10a. State 10b. County		10c. City,	Town or Lo	ocation						1	Od. Inside City Limits
	Ba-f	cto	MD Anne A	rundel	La	urel		<u> </u>						1 ☐ Yes 2XXNo
	ith th	Oire	10e. Street and Number				10f. Zip	Code				10g. Citiz	zen of What Cour	ntry?
	23a	rai	3348 Cranberry S	•					724				USA	
	tans tans	nue	11. Marital Status	12. Was Dece Armed For	dent Ever in U.S rceş?	13.	Was Deced	ient of Hi	spanic Orig	gin? (Spec	ify Yes or No- ican, etc.)	1	 Race - Americ Black, White, 	
36	or I	γFi	1 Never Married 2 Married	1 □Yes If Yes, Giv	'e		1 🗆 Yes	X □ No	Specify:				Specify: Wil	nite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. khar than "natural", or Itams 23e or 28e-f show ant, It e Madical Examinat roust be mailtied at	Completed by Funeral Director	3 ☐ Widowed 4 ☒ Divorced	Year or Da	ates:	10 0								
5	"nat	iete	15. Decedent's E (Specify only highest g			(Give	dent's Usua kind of woi DO NOT us	nk done d	ition u <i>nng m</i> ost	of working	7		nd of Business/Ind Govern	,
12	withi	m.	Elementary/Secondary (0-12)	College (1	-4or 5+)		ofread						nting Of	
12	Hygie thar nt,	e Co	17. Father's Name (First, Middle, Las			FLO	orread	uer	18 Mother	r's Name (First, Middle,			
Maryland	d tal	<u>m</u>	Leo Clay	-7							hnson		our ano,	
7	should nd Men marka umatic	၉	19a. Informant's Name/Relationship	(Type Print)		19h Mailii	an Address	(Street a				r City or	Town, State, Zip	Code
Ma	d 2 s th an 17 la trau		Laurie Konopacki		r		-				e, MD		075	Codey
	1 and 2 Health tam 27 I		20a. Method of Disposition	, baagiice	20b. Pla	ace of Dispo	sition (Nan	ne of		Da			cation - City or To	own. State
Baltimore,	Pages nent of I int: If its ury or o		1 ☐ Burial 2 🗡 Cremation 3 i		State Cer	metery, crei	natory or of	ther place		0 /16 /	2005			
ij	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Spec21. Signeture of Funeral Service Lice	•	wes	t Aru				9/16/			nton, MI eral Hon	
Ba	Depa Impo any ir		21. Signeture of Funeral Service Lick	Down	120110						Laurel			me, P.A.
	40200	-	220 Part Paratha finance		M0110								20/0/	A
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	y one cause on e	ach line.	Do not en	er the mode	e or ayıng	, such as	cardiac or	respiratory ari	rest,		Approximate Interval Between Onset and Death
	Physician	i	Immediate Cabse (Final disease or condition resulting in death)	_ aCe	rebral '	Throm	oosis							Minutes
	/Medical Examiner		resulting in death)		or as a conseque	-								
Н	-40	_	Sequentially list conditions,	h	ongestive		ct Fai	Llure	=					Days
b	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,	rdiomyo									Years
(and I-tran	Examiner	that initiated events resulting in death) Last	C	or as a conseque									rears
58760,	icate be executed physician and s the burial-transit	al E		20010 (
87	phys the	dical	•	d										
	death certific e attending p id for use as	Physician/Me	IF FEMALE:	23c If yes out	come of pregnan	cv								
Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live bi	irth 2 ☐ Fetal o ant at time of dea	death 3	Ectopic pre					23	3d. Date of deliverMonth	ory Day Year
o.	0 0 2	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno		atri 5L	Other (spe	өспу)						
<u>α</u>	that the death hed by the atter detached for	Ph	Part II. Other significant conditions	contributing to de	ath but not result	ting in the u	nderiving ca	ause give	n in Part I.		23e. Did to	bacco us	se contribute to th	ne cause of death?
Records,	es be	d by					, , ,				1 🗆 Y	es 2	No 3¥7 Prob	ably 4 □Unknown
Ö	w requir been si should	etec									-		• •	
3ec	elaw has l	Completed									24a. Was a autops perfor	sy	24b. Were auto prior to cor death?	psy findings available npletion of cause of
_	ysician: The l is certificate ha director, page	S										2 No		2 No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Otho		of Death (Check only or	10)		
of	this aldir	ို	1 ☐ Yes 2 🔀 No 27. Manner of Death	الكلاا		R/Outpatier			4 🗆 1401				Other (Specify	/)
	Jing I	ion	1 ⊠Natural 5 ☐ Pending		of Injury h, Day Year)	28b. Time of Injury		8c. Injury Work			d. Describe h	ow injury	occurred	
Division	I or Attanding I after death. Diractor: After I in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not		of lainer. At hom		М		es 2□N		f 1 /C	444		10
-	after death Diractor: in by the	ertif	4 ☐ Homicide determined	buildir	of Injury - At hom ng, etc. (Specify)	ie, iaim, str	eet, factory	, опісе		20	City or Town	n, State)	Number or Rura	raoure ivumber,
i,-d	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral		29a. Certifier 1X Certifying P	hyeidige: To the	haet of mir bassin	lodge dect		na abare ate :	a data as	d alaata i	al alva 6 - 15 -			
	Hos 24 hc Fun stely	edical	(Check only 2 Medical Exa	hysician: To the miner: On the ba and mann	isis of examination	on and/or in	estigation,	in my op	e, date and inion, death	piace, an h occurred	a due to the c at the time, d	ause(s) a late and p	and manner as st place, and due to	ated. the cause(s)
	thin the mple	Mec	29b. Signature and title of centifier	and mann	A. N		290	. Lisense	number		7 2	9d. Date	signed (Month, I	Dav. Year)
	F 3 F 8		11/1/1/1/2	A	11/2.			1	12	916				
	1		William	-/ (1	Jun		<	ال)	116		pept	tember l	J, 2005
	10		30. Name and address of person who											
	-01		321 Prince Geo:		et, Lauı Əgistrar's Signatu		2 עו	20707		Wil.	liam A.	. War	ren	
	Sta Registr		SEP 2 0 200		· M	Lioss	E.							

State of Maryland / Department of Health and Mental Hygiens 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 6:30 P M Virginia M. Carper September 15, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Genesis Eldercare Hammonds Brooklyn Park Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Q1 Months Days Hours Min. 8. Date of Birth (Month, Pay, Year) Jan 1, 1924 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 XF 81 Vrs Maryland Director 219-16-2856 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 27 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, it a Modical Examiner must be notified at 1 X Yes 2 □ No Directo N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 636 Sunset Strip USA 2 should be filled within 72 hours after deeth and Mental Hygiene. Is marked other than "natural", or Itams 23s Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Hairdresser 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 Is marked oth any linjury or other traumatic event <u>once.</u> Be Charles Corrieri Catherine Suit 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6501 Fable Court Glen Burnie, Maryland 21060 Thomas Carper, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland 9/16/05 Metro Crematory Inc. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ^{22. Name and Address of Facility}
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** (416) AUDOLON disease or condition resulting in death) /Medical Due to (cr as a consequence of): Examiner MANOJO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ eq 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Be Completed Failure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Heart 24a. Was an certificate has autopsy performed? 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4M Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1% Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 023465 s of person who completed cause of death (Item 23a) (Type, Print) Glen Burnie, MD 21061 2485 Jude Muheres 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 0 2005 Registrar

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of F <i>rtificate of a</i>			en 2005	30446
			1. Decedent's Name (First, Middle, Las)	· ·			2. Date of Death Month	n Day Year	3. Time of Death
	Physici /Medic		Doris Johnso	n Carmen				Septembe		5 10:10 A M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	1	4c. County of Dea	th
			Manor Care Health	Services		Towson			Baltim	ore
	Funeral		Social Security Number 6. Security Number	7. Age	e (In yrs. last birthday)	If Under 1 Year Months Days	ff Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
13	Director		220-14-4956	JM 20JF	81 Yrs.			Nov. 3,		aryland
	pur *		Usuaf Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. fnside City Limits
	the Marylan 28a-f show	5	,							1 ☐ Yes 2√∑ No
	Ne N	ect	Maryland Baltimo	re	Baltimo	10f. Zip Code		10	og. Citizen of What Co	nuntry?
	with t	큡	2812 Topaz Road	ı		21234	1	10	USA	Junty
	s 23a	erai	11. Marital Status	12. Was Decedent I	Ever in U.S. 13			pecify Yes or No-	14. Race - Ame	erican Indian.
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I then "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examitter count by or published at	Funeral Director	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🛣	40	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	o Rican, etc.)	Black, Whi	
21215-0036	urs aft	by	3 XWidowed 4 ☐ Divorced	ff Yes, Give Year or Dates:		1 ☐ Yes 🏂 No	Specify:		Specify:	White
0-0	"natural",	Completed	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	ation	king 1	16b. Kind of Business	/Industry
215	within 7 ene. than "n	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retired	d)	Amy		
21	filed with Hygiene. ther ther	, Lo	12		Cler	k				anufacturer
pu	be filed tal Hygid d other event,	Be (17. Father's Name (First, Middle, Last)					ne (First, Middle, M		
Va	should be filed within nd Mental Hygiene. imarked other than umatic event, the Mental than the matic event, the Mental than the matic event.	2	Albert Clarence	Johnson			Helen	Jeanette	Mahan Mahan	
Maryland	and and is my		19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Number,	City or Town, State,	Zip Code)
	and ealth m 27		Tracy A, Johnson	/ Niece	281	2 Topaz R	coad, Bal	timore, M	Maryland 2	1234
ore	ges 1 If itel or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Bernoval from State	20b. Place of Dispo cemetery, cre	matory or other plac	ce)	Date 2	20c. Location - City or	Town, State
Ë	Peg ment ant: jury c		4 □ Deplation 5 □ Other (Spearly	Y X//		Memorial		17-05 E	Baltimore,	Maryland
Baltimore,	permit. Peges 1 and 2 Department of Health a important: If item 27 is eny injury or other trai once.		21. Signature of Funeral Service Ligen		1	2. Name and Addre MCCOMAS F 1317 Colco	uneral H	ome, P.A.	don Marri	1 and 21000
	1-10		23a. Part 1 Enter the disease, or composite of composite	elications that caused	the death. Do not en	ter the mode of dying	ng, such as cardiac	or respiratory arre	ist,	land 21009 Approximate
4	Dharinian		mmediate Cause (Finaf disease or condition	one cause on each lin	10. E12.02 1/	Acr 111	40	TUDIA	180610	fntervaf Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	EBROV.	VICUL	· / / /	1/1/61	100013	M. 17
	Examiner			cord		OKE				Months.
4	90	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as	a consequence of):					
	outed ansit	E		C						
00	tificate be executed ig physicien and as the burial-transit	edical Examiner	resulting in death) Last	Due to (or as	a consequence of):					
68760,	cate b	dica	•	d						
_	ding p	/Me	IF FEMALE:	23c. ff yes, outcome	of pregnancy				204 Date of de	
Box	that the death certifi ed by the attending detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	1		23d. Date of de Month	Day Year
o.	9 9 9	ysic	1 ☐ Yes 2 ØNo 9 ☐ Unknown	9□ Unknown	time of death 50	Ottler (specify)			:	
Δ.	res that the igned by be detact	, Ph	Part fl. Other significant conditions of	ontributing to death b	ut not resulting in the u	inderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	o the cause of death?
Records,	w requires that the been signed by th should be detache	ed by						1 ☐ Ye	s 2□No 3□P	robably 4 Minknown
S	> Q to	Completed						24a. Was an		utopsy findings available completion of cause of
	0 5 0	Eo						perform	ed? death?	2 No
tal	ician: The certificate rector, pag	a	25. Was case referred to medical				26. Place of Dea	th (Check only one	•	
>	Physician: this certific ral director,	To B	examiner?	Hospitaf: 1 ☐ Inpatie	nt 2 ER/Outpatie	nt 3□ DOA Oth	er: Nursing H	ome 5 Resider	nce 6 Other (Spe	icify)
0	ig Phys ter this neral di	ü.	27. Manner of Death 1/☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time o	of 28c. Injur Wor	y at k?	28d. Describe hov	w injury occurred	
Ö	Attending r death. ector: After by the fune	atic	2 Accident investigation			M 1 🗆	Yes 2 □No			
Division of Vital	or Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Pface of Injuding, etc	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
	pitel		On Continue Management	Jaio T. M. B. A.	-6 (1					
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) Certifying Ph (Check only one)	iner: On the basis of and manner sta	of my knowledge, deat f examination and/or in ated.	n occurred at the tir vestigation, in my o	ne, date and place ppinion, death occu	rred at the time, da	ite and place, and du	s stated. e to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	21	/	29c. Licens			d. Date signed (Mont	_
	6		1/1/6	Willed.	in in	400	12840	7	9-14-	
4	6		30. Name and address of person who	completed cause of d	eath (ftem 23a) (Type,	Print)	-10 D	1. 7	LARI MY	21204
	ソ		31. Date filed (Month, Day, Year)	20 Desile	/ COO		01	1000	2010 115	, , , , , , ,
	Sta Regist		SFP 2. 0.2		ar's Signature	carles				

ORIGINAL

			For State Registrar	State of M	arylaı				ealth a	and Mo		giene		301	47
	Physici /Medic		1. Decedent's Name (First, Middle, I	Carnic							2. Date of De Month	ath Day		3. Time of	
	Examir Funeral	ner		y General	L Ho	last birthday)	1 (olumi r 1 Year	Location of Dia If Under 2 Hours		8. Date of Bir	I.	County of Dealoward	tholace (State of	or Foreign
*	Director	<u>_</u>	109-14-0324 Usual Residence of Decedent 10a. State 10b. County MD	8		Yrs. ity, Town or Lo					3/20/2	21	No	ew York 10d. Inside C	•
3	3a or 28e-f	i Director	Howard 10e. Street and Number 9606 Basket Rin	ng Road	Co	lumbia		p Code				10g. Citi	zen of What C		2 No
9800	De liled within 72 nours after death with the Maryland ital Hygiene. Ital Hygiene do other then "natural", or iteme 23a or 28e-f ehow event, the Madical Examinar must be notified at	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☼ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 TYPS 2 If Yes, Give Year or Dates:				dent of Hi ecify Cubar 2 X No		in? (Spec , Puerto R	cify Yes or No lican, etc.)		14. Race - Am Black, Whi Specify: W	e, etc.	
Baltimore, Maryland 21215-0036	iled within 72 h tygiene. her then "natu nt, the Madical	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12) 12	rade completed) College (1-4or !	5+)	16a. Deced (Give life. L Secur	kind of wi OO NOT i	ork done d ise retired) Guar	uring most			U.S.		Industry	rnmen
ırylanc	snould be filed and Mental Hygis marked other imatic event, in	To Be	17. Father's Name (First, Middle, La. Matteo Carnice 19a. Informant's Name/Relationship	l1i		19b. Mailin	a Addres		Marg	garet	(First, Middle, Pater	elli		Zin Codo)	
ore, Ma	pes 1 and 2 of Health a of tem 27 le or other trau		Jean Simon (Da 20a. Method of Disposition 1 X Burial 2 □ Cremation 3		20b. I		2 Ri	ders	Mark		nond, O	K 7	3003 cation - City or		
Baltim	permit. Pages 1 and 2 should be Depertment of Health and Menta Importent: If Item 27 ie marked eny injury or other traumatic evonce.		4 Donation 5 Other (Spec	city)	Со	lumbia ²²². W	Name a itzk	nd Address e Fui	s of Facility neral	Home	es, Inc		kesvill	Le, MD	
P	hysician /Medical Examiner	-	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Cequentially list conditions, if any, leading to immediate gause. Enter Underlying	a. Athero Due to (or as	s consec	th. Do not enter	r the mo	de of dying	i, such as c	ardiac or	respiratory ar	rest,	ia, MD	21045 Approximate Interval Bett Onset and D	ween
8760, <	the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as											
.O. Box 6	y the attending placehold for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	il death 3 □l	Ectopic p Other (sp	regnancy pecify)				2	3d. Date of del Month		'ear
ords, P	been signed by the a should be detached t	Ď	Part II. Other significant conditions	contributing to death bi	ut not res	ulting in the un	derlying o	ause giver	n in Part I.			bacco us		the cause of de	
tal Reco	certificete has be	e Completed	25. Was case referred to medical							_	24a. Was a autop: perfor 1 Yes	med? 2021No	24b. Were au prior to death? 1 \(\subseteq \text{Yes}	topsy findings a ompletion of ca 2 No	ivailable luse of
Division of Vital Records,	After this	ToB	examiner? 1 Yes 2 No 27. Manner of Death 1		v	ER/Outpatient 28b. Time of Injury		Other Bc. Injury a Work?	4 □ Nurs	sing Home	Check only or ⇒ 5 ☐ Resident d. Describe h	ence 6	Other (Spec	ify)	
Divis	in by	Certification:	3 Suicide 6 Could not determined	building, etc	: (Specif	y) 					City or Town	n, State)		ral Route Numb	98r,
To the Hospital	within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) 1 ☑ Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the best of miner: On the basis of and manner sta	of my kno examina ted.	wiedge, death tion and/or inve	occurred estigation	at the time in my opii	nion, death	place, and occurred	d due to the c at the time, d	ause(s) a late and p	and manner as place, and due	stated. to the cause(s)	
	15× 5		30. Name and address of person who	completed cause of de	eath (Iten	1 23a) (Type. P	rint)	D4	372	5		C	11181	05	21
	Sta Registra		TARIQ MAIM 31. Date filed (Month, Day, Year) SFP 2.0	completed cause of de 2005	- (Oʻ	9 Bac	IC!	Zive	rN	eck	New	d	Ralfi	more	,

_			1 - For State Registrar	te of Maryland / De	partment of	of Health and of Death	d Mental Hygi	ene 2005	30448
	Physic	ian	1. Decedent's Name (First, Middle, Last) Anna Emma Dell'Acqua		•		2. Date of Death		3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give street a	nd number)	4b. City, Tov	vn, or Location of De	Septembe	Day Year 2005	1:45 P. M
		All:	501 S. Ponca Street			altimore			/A
	Funeral Director		5. Social Security Number 219-30-1794 Usual Residence of Decedent	7. Age (In yrs. last birthda 71 Yrs	Months D		lin. (Month, Day,	9. Birtl 07,1934 Ba	hplace (State or Foreign untry) 1 timore, MD.
	nylanc show	_	10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	the Ma	Director	Maryland N/A	Baltimo					1 XYes 2 □ No
	3a or	ā	501 S. Ponca Street		10f. Zip Co		10	g. Citizen of What Co	•
	death	Funeral	11. Marital Status 12. Was	Decedent Ever in U.S. 1 ed Forces?	3. Was Decedent	21224 of Hispanic Origin?	(Specify Yes or No- erto Rican, etc.)	United St	ncan Indian,
36	within 72 hours after death with the Maryland ene. then "naturst", or Items 23e or 28e-f show ra Madical Exemples rivest be multiped at	by Fu	1 Never Married 2 Married 1 If Ye	Yes 2X No es, Give	1 ☐ Yes 2 ☐		епо нісал, еtс.)	Black, White	
9-0	72 hours "naturs!",	ted t	15. Decedent's Education	r or Dates:	cedent's Usual O	ccupation	11	6b. Kind of Business/I	White
215	d within 7. piene. r than "n ine Modi	Completed	(Specify only highest grade compl	ege (1-4or 5+) (Gi	ve kind of work do . DO NOT use re	one during most of v atired)	vorking	DO. ITHING OF CUSHIOSSY	ndustry
121	ifiled w Hygier other the		12 17. Father's Name (First, Middle, Last)	N/A Den	tal Lab	Technicia		Denta	11
Maryland 21215-0036	ed la la la la la la la la la la la la la	To Be	Carl Frank Gawens				lame (First, Middle, Ma eth Debus	uden Sumame)	
lary	and and ie m	-	19a. Informant's Name/Relationship (Type, Prin		iling Address (St		Rural Route Number, (City or Town, State, Zi	ip Code)
S O	Health Health tem 27		Mrs. Denise K. Avery(I	- Parketon - Inches		t Street		e, Marylar	nd 21224
Baltimore,	Pages I nent of H ant: If ite		20a. Method of Disposition 1 □ Burial 22 □ Cremation 3 □ Removal	Irom State	rematory or other	place)	. 10 0005	c. Location - City or T	
altin	글론 본 글 .		4 □ Donation 5 □ Other (Specify) 21. Signature ■ Funeral Service Licensee	Evans Fu				Forest Hil	1, Maryland
ä	Depa Impo any i	5	Mary f. g	ar, Se.	eacetul 2325 Yor	Alternáti k Road T	ves Funera imonium, M	l&Crematio arvland 2	on Ctr.,P.A.
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. Do not e on each line.	inter the mode of	dying, such as card	ac or respiratory arres	1.	Approximate Interval Between
To all	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	lung can	ar				Onset and Death Yeak
Til.	Examiner			e to (or as a consequence of):					0
· /	p #	Iner	Sequentially list conditions, if any, leading to in modulate cause. Enter Underlying Cause (Disease or injury that initiated events c.	e to (or as a consequence of):					
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68 9	ing physes as the	Medi	IF FEMALE:						
Вох	leath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	s, outcome of pregnancy ive birth 2 Fetal death 3	□Ectopic pregna	incy		23d. Date of deliv	ery Day Year
o.	at the de by the a tached	hysic	1 ☐ Yes 2 M2No 9☐ Unknown 9☐ U	Pregnant at time of death 5 Jinknown	Other (specify)		, which the	Duy Foar
S, D	es tha igned be de	by Physician/Me	Part II. Other significant conditions contributing	to death but not resulting in the	underlying cause	given in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
ord	w requir been si should	eted					1 Tes	2 □ No 3 ₽ Prot	bably 4 Unknown
Rec	he law e has l ige 2 s	Completed					24a. Was an autopsy performed	prior to co	opsy findings available impletion of cause of
Division of Vital Records,	ysician: The is certificate hadirector, page	Be Co	25. Was case referred to medical	20-		26 Place of De	1 ☐ Yes 2 ②		2 No
> <	Physic this ceral direct	To	examiner? 1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outpati	ent 3 DOA	Other: 4 Nursing		e 6 ☐Other (Specif	y)
ouo	ding After funer	tion:		Date of Injury 28b. Time Month, Day Year) Injury	of 28c. I	njury at Nork?	28d. Describe how	injury occurred	
NSI.	Attending or death. Sector: After by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e.	Place of Injury - At home, farm, s		Yes 2 No	28f. Location (Stree	t and Number or Rura	al Boute Number
	ital or rs afte ral Dire	Cert	Tomordo	ouilding, etc. (Specify)			City or Town, S	itate)	
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical		o the best of my knowledge, dea he basis of examination and/or i	ath occurred at the	e time, date and place by opinion, death occ	e, and due to the caus curred at the time, date	e(s) and manner as s and place, and due to	lated.
	To the	Me	29b. Signature and title of certifier	manner stated.		ense number		Date signed (Month,	
	^		I Kima Conge	Mo	D	0046988			
	5		30. Name and address of person who completed	cause of death (Item 23a) (Type to Easteln Av	, Print)	R-1-	404. Ac.	> > > > > > > > > > > > > > > > > > > >	
	Sta	te	RIMA COURT, 494 31. Date filed (Month, Day, Year)	2. Registrar's Signature	enue,	Balti	roke , MI	12124	
	Registr		SEP 2 0 2005	2. Registrar's Signature	also a				

			. For	State of Maryland					•	
			1 - State Registrar		Cer	tificate of	Death	Reg	2005	30449
	Physici	an	Decedent's Name (First, Middle, Last)					Date of Death Month	Day Year	
	/Media		Euva Rut 4a. Facility Name (If not institution, give s			4b. City. Town. a	r Location of Death	Septembe	er 19, 20 4c. County of De	
	LXaiiiii	lei	Genesis Knollwoo				rsville			Arundel
	Funeral		5. Social Security Number 6. Sex 229-14-6658 1□		t birthday). 9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	(ear) 9. Bi	rthplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	0	9 115.			May 24,	1916 Wes	st Virginia
	aryland show	_	10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	28a-f	Director	Maryland Anne Anne Anne Anne Anne Anne Anne An	rundel		Mi.	llersville		0.00	1 ☐ Yes 2 No
	h with	I DI	130 Linda Lane			211	.08	100	g. Citizen of What C USA	ountry?
	ams 2	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	13. V		lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No-	14. Race - Am Black, Wh	
36	rs afte	y Fu	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		☐ Yes 2X No	Specify:	110211, 010.7	Specify:	White
5	within 72 hours after death with the Maryland ene. Than "natural", or Itams 23e or 28e-f show Ite M. Jical Exa. ill'er F. ust Le netified al	Completed by	15. Decedent's Educ		16a. Deced	ent's Usual Occup	ation	16	Sb. Kind of Business	s/Industry
21	ithin 7	nple	(Specify only highest grade Elementary/Secondary (0-12) 12	College (1-4or 5+)			ation during most of workii d)	ng		
22	filed w Hygier other th	Col	17. Father's Name (First, Middle, Last)		LI	PN .	18. Mother's Name	/First Middle Ma	Hospita	1
au	lid be lental ked o ic sve	To Be	Walter Grimes					Hogsett	iden Sumame)	
Maryland 21215-0036	2 should and Men is marke sumatic	-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailin	g Address (Street	and Number or Rura	Route Number, C	City or Town, State,	Zip Code)
6,≥	1 and 1ealth 9m 27 ther tr		Jackson T. Webb/		130	Linda La	ne Mille		MD 21108	_
μoμ	Pages nent of I int: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	omoval mom state		sition (Name of patory or other place)	1		C. Location - City of	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if tiem 27 is marked other than "natural, or flams 23a or 28a-1 show any injury or other traumatic avent, the Marical Examinations and the notified at ODGs.	-1	21. Signature of Funeral Service License	1	22	Name and Address	e of Eacility	53-575	Baltimor	
<u> </u>	\$ 0 E 8 8		Edward A. Greg	gorchik		299 Frede	Society crick Road	or MD, 1 Baltim	nc. ore, MD 2	1228
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. I be cause on such line.	Do not ente	or the mode of dyin	g, such as cardiac o	r respiratory arrest		Approximate Interval Between Onset and Death
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Е	Examiner		Sequentially list conditions b.							
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89 X	death certificate e attending phys d for use as the	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregnancy	,		-			
POX	death e atten d for u	lcian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal de 4 Pregnant at time of deatl	ath 3 □I	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
o.	the sche	hys	9 Unknown	9□ Unknown						
S,	law requires that as been signed b 2 should be deta	þ	Part II. Other significant conditions cont	tributing to death but not resultin	ng in the un	derlying cause give	en in Part I.	23e. Did tobac		the cause of death?
Hecord	w requ	ompleted						24a. Was an		
r	ا يو ع	ошо						autopsy performe	death?	utopsy findings available completion of cause of
	yaician: Th	Be C	25. Was case referred to medical examiner?				26. Place of Death		No 1 □ Yes	2□ No
ō :	this aldi	2	1 ☐ Yes 2 ☐ No ☐ Ho 27. Manner of Death	The state of the s	Outpatient	3☐ DOA Othe	47 Wursing Hom		e 6 Other (Spe	cify)
Vision	nding Phy ath. r: After thi e funeral (atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work	:?` ∕es 2 □No	8d. Describe how	injury occurred	
<u> </u>	or Atta ter dec irecto irecto	ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, office	2	Bf. Location (Stree City or Town, S	t and Number or Ri	ural Route Number,
ם	lo the Hospital of Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	O	29a. Certifier 1 Certifying Physi	iniana. To the heat of my knowle	des dessit				,	
	lo the Hos within 24 ho To the Fun completely	edical	(Check only 2 Medical Examination)	ician: To the best of my knowle er: On the basis of examination and manner stated.	and/or inve	estigation, in my op	e, date and place, at pinion, death occurre	d at the time, date	e(s) and manner as and place, and due	to the cause(s)
1	vithir To th	ž	29b. Signature and title of certifier	1.00	_	29c. License	- 4	-9	Date signed (Mont	
	0		10mlu	Villen	()	195	1136	56	PIZMBE	R
	4		30. Name and address of person who com	npleted cause of death (Item 23	a) (Type, P	rint)	BRIDGE	D BATT	710015	(IL) 2/236
	Sta		31. Date filed (Month, Day, Year)	32. A gistrar' Signatur	1700	nadi s	51-176 1-	7 5101	mace	01006
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06265		1 - For State	State of Ma	irylan				lealth a Death	and Me	_	•	200	าธ	201 50
		Registrer 1. Decedent's Name (First, Middle, Las	st)			inoat	0 01 1	Joann		2. Date of De.				3. Time of Death
Physicia /Medica		Balanca Yesseni	a Dubon							Month Septem	ber	$^{19}12.$	Year 2005	11:58 AM
Examine		4a. Facility Name (If not institution, give						Location of	f Death	•	40	. County o	f Death	
		Good Samaritan Ho 5. Social Security Number 6. S		(In ure I	ast birthday)		Ltimo		24 Hrs.	9 Date of Birt	h	n/a	9 Righals	ace (State or Foreign
Funeral Director			ПМ 2ПЕ	15	Yrs.	Months		Hours	Min	8. Date of Birt (Month, Da Oct. 2	y, Year, 2 19	989	Counti	nduras
yiand Now		10a. State 10b. County		10c. City	, Town or Lo	cation							10	d. Inside City Limits
Deficiencies, IMEI VIGITIES A. I. 2. 2000 permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel, or iteme 23s or 28s-1 show eny injury or other traumatic event, the Medical Examinar must be notified at page.	cto	unknown unknow	/n	uj	nknow	_								1 Yes 2 No
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Variant Pand		19a. Informant's Name/Relationship (-				Route Numbe	-			
To I and Health Health Ither to	-	Lucia Stockman 20a. Method of Disposition	friend	20b. P	ace of Dispo	sition (Na	me of		#301 Da	, Timo		ocation - C		
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permit. P Departme importan eny injur.	ŀ	21. Signature of Funeral Service Dices	see				nd Addres							
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		23a. Part1. Enterthe disease, or conschools or bear failure. List only	olications that caused one cause on each lin	the death e.	. Do not ent	er the mod	de of dyin	g, such as c	cardiac or	respiratory ar	rrest,	-	1	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	a Stab are	rund	5(2)	to to	re n	rik a	wel	Chest				
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engi Becci	2	Part II. Other significant conditions of	ontributing to death bu	it not resu	ilting in the u	nderlying o	ause give	en in Part I.		23e. Did to				cause of death?
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The it	E										rmed? 2 ☐ No	de	ath?	pletion of cause of !□ No
ertifica sctor,	Be C	25. Was case referred to medical examiner?					To		of Death	(Check only o	ne)			
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Affer and C	tlon Lon	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury Found 11:	21 M	28c. Injury Work 1 ☐ `	(? Yes 2. ∑ ″N		Subject			1	
Atten r deal ctor	Certification:	3 Suicide 6 Could not b	e 28e. Place of Inju	ry - At ho	me, farm, str					Bl. Location (S City or Tow	Street ar	nd Number	or Rural	Route Number,
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Hospi 24 hour Funer rely fill	edical		nysicien: To the best on niner: On the basis of and manner sta	examinat										
o the	Me	29b. Signature and title of certifier	and marrior sta			29	c. License	number			29d. Da	ite signed	(Month, D	ay, Year)
->-0		> Zalin	43;	4	R1	0	CME				Sen	tembe	r 13	, 2005
2		30. Name and address of person who	completed cause of de	eath (Item	23a) (Type,		<u></u>				~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~			,
V		31. Date filed (Month, Day, Year)	32. Registra	rio Girano		11 Pe	nn S	treet	Balt	imore,	Ma	rylan	d 21:	201
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 30451 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 18, 2005 Physician 10:26A M William Leonard Davis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sykesville 1731 Route 32 Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 18, Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours **X**□M 2□F 84 212-12-2404 Yrs Director 1921 Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "naturel", or fleme 23a or 28a-f show traumetic event, the Medical Examinar must be notified at MD Howard Sykesville 1 Yes 2 No Director 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 1731 Route 32 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: WWII White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "n any rigury or other traumetic event, the Med appring or other traumetic event, the Med apprica. Elementary/Secondary (0-12) College (1-4or 5+) 12 Construcion Supervisor Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Leonard Davis, Sr. Rosemarie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1731 Route 32 Sykesville, MD 21784 Mrs. Arlene M. Davis (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Mem. Gardens 9/23/05 Marriottsville, MD 21. Signature of Funeral Service Licenses HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Artherescleratic cardio vascular diease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hypertention if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of): burial-transit erlindemia Box 68760, attending physicien ician/Medicai as the t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached Physi 9□ Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan ormed? 2 Ø No 1 ☐ Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Certification: 1 🗷 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier cai completely (Check only one) and manner stated

Court Old 5400 31. Date filed (Month, Day, Year) SEP 2 State Registrar

29b. Signature and title of certifier

9922

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 2005

Road \$108 32. Registrar's Signature

Elesur & port

29c. License number

Randellstown

29d. Date signed (Month, Day, Year)

2005

September 20

21133

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			State of Maryland / Department of State of Maryland / Department of Certificate	of Health and M of Death	lental Hygier	2005	30452
	Physici		1. Decedent's Name (First, Middle, Last) Paul Preston Dayhoff Jr.		2. Date of Death	Dav Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, To	own, or Location of Death		4c. County of Death	
2	Funeral Director		5. Social Security Number $\begin{array}{c ccccccccccccccccccccccccccccccccccc$	Days Hours Min.	8. Date of Birth (Month, Day, Ye Aug 19 19	ear) Cou	place (State or Foreign ntry)
′. —	Maryland e-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Lisbon				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
07447077 6	h with the 23a or 28 1st be no	al Dire	10e. Street and Number 15919 Frederick Road 217	ode 765	_	Citizen of What Cou	ntry?
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "natural", or Items 23a or 28e-1 show any injury or other traumatic event, the Medical Evantment must be notified at Once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Mo If Yes, Give Year or Dates: 13. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Mo If Yes 2 Mo If Yes 3 Mo	nt of Hispanic Origin? (Spe y Cuban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: whi	, etc.
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AUし Baltimore,	Pages 1 ament of He ent: If itam ury or other		20a. Method of Disposition 1	MC Cem. 9-19∙	-05 Ta	: Location - City or T $ylorsvill$ (e, Md
ACL Baltim	permit. Departi Import any inj			Address of Facility Hai:			Chape1
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P.O. Box 68	requires that the death certifica ween signed by the attending ph hould be detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic preg 4 ☐ Pregnant at time of death 5 ☐ Other (speci			23d. Date of deliv Month	ery Day Year
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of Vita	iding Physician: Th th. : After this certificate funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c	26. Place of Death Other: 4 Nursing Hor			(y)
Division of Vital Records,	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide	Work? 1 □ Yes 2 □ No office 2	28f. Location (Street City or Town, St	t and Number or Rura tate)	al Route Number,
_	a Hospita 24 hours a Funarel etely filled	Medical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	the time, date and place, a my opinion, death occurre	and due to the cause ed at the time, date :	e(s) and manner as s and place, and due to	stated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier 29c. L	icense number	29d. l	Date signed (Month,	Day, Year)
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COURT SHANKAR C-MACANNA 7	US 9552	RD WES	5 MIN 57E	e mo
8	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 0 2005 32. Registrar's Signature				

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		A	Northwest + 5. Social Security Number	6. Sex 7.	Ann /In ure	last birthday)	Rand		If Under 24		1	ALTIMI	
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	and w		Usual Residence of Decedent 10a. State 10b. Count	у	10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
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	Heelth and Melan 27 is marl		19a. Informant's Name/Relation Deborah A. Ebe			19b. Mailir 330 H	ng Address ighfa	(Street a	Rd.,	or Rural Route Nu Reisters	mber, City town,	or Town, State, Md. 21	Zip Code) .136
ω.	Definit. Fages 1 of Department of Hee Important: if Itam any injury or othe Once.		20a. Method of Disposition 1 ☐ Burial 200 Cremation 4 ☐ Donation 5 ☐ Other (3		ate C	Place of Disponentery, cremetery, cremetery	matory or of	ther place	Sept	Date . 21, 20		ocation - City o	
Balt	Department Important any injury		21. Signature of Funary Service	Ligeofee		22		ardt	Funer	al Chape			21117
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,	/Medi Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	septemb.	4c. County of Death	10:50 PM
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	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		1	0d. Inside City Limits
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	h the	rec	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Coun	try?
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	tems	nue	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	rs afte	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	, ,		hite
21215-0036	72 hours after natural', or ite	ted t	15. Decedent's Education 16a, Dec	cedent's Usual Occupation	161	b. Kind of Business/Inc	hustor
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Maryland	2 should be filed within 72 hours and Mental Hygiene. is marked other than "natural", if aumatic avent, If a Medical Ex-	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Mail	,	
Ž	hould d Mer marke	10	Joseph Finch 19a. Informant's Name/Relationship (Type, Print) 19b. Ma		othy Gils		
	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, the Marical Examinent: ust be rediffed at ance.			illing Address <i>(Street and Number or Rura</i> Water Oak Point Rd			
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Baltimore,	Page nent c int: # iry or		1 ☐ Burial 2 IXCremation 3 ☐ Removal from State Bay 128 (*) 1 ☐ Sonation 5 ☐ Other (Specify)	Tenatory, of the chace) Inc. 9-22-	2005 Ba	ltimore, M	Th
alt	permit. Departn Imports any inju	1	21. Signal, e.f. ineral Service License	Name and Address of FacilityAmbre	ose Funer	al Home, T	nc.
	80 E # 9	1	LIVANIAN KARANTANIAN	1328 Sulphur Spring	Rd., Arb	utus, MD 2	1227
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or	r respiratory arrest,		Approximate Interval Between
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		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ENCETABLO	HHY		2 0775
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,00	cate be executed bhysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
8760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	dical	d				
Вох 6	eath certific attending p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			201 5 (11)	
B.	death a atter d for u	Physician/M	in the past 12 months? 1 Live birth 2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of deliver Month	y Day Year
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ord	w require been si should b	ted	CEREBRO VASCULAR	DISEASE	1 ☐ Yes	2 No 3 Proba	bly 4 🖔 Unknown
Records,	has b	Completed by	HEPATITIS "C"		24a. Was an autopsy	prior to com	sy findings available pletion of cause of
a F	i cian : The certificate ha rector, page		SUBSTANCE ABUSE		performed 1 ☐ Yes 2 ☐	? death?	2□ No
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ō	y Physer this eral di)—	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c, Injury at 28	le 5 ☐ Residence 8d. Describe how in	6 □Other (Specify)	
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	To tha Hospital or within 24 hours after To tha Funaral Dire completely filled in b	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	ath occurred at the time, date and place, ar nvestigation, in my opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as sta	ted. he cause(s)
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	⊢ 3 ⊢ ŏ		- Salotel MD.	D 23300	51	FPTEM RFE	2 17 200
	1		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) 130N KELL	ves 2	04/	- //
	5		29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type 5 V D H) R · PATE2 . 20 31. Date filed (Month, Day, Year) 32. Registrar's Signature	00 W. 13A2TV. 5	T. 13A	250 110	, 2/223
1	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Anaski s			
	Registr	df	SEP 2 0 2005 Market A	9			

Amend item#4c_10a.perMD, FH, G847.9/20/05 TT Ensure All Copies Are Legible.

For TUB State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** 5:00 Naomi Jeptember 15,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltmore If Under 1 Year If Under 24 Hrs. Harview Avenue 7. Age (In yrs. last birthday) Yrs. 5. Social Security Number 6 Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 25 €F Months Days Hours Min Director 219-10 6,1924 Marylan -10866 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Iteme 23a or 28a-f show other traumatic event, the Mudical Examinar must be mudical. Yes 2 No Director altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2123 Avenue 30 death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 15 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Im 27 is marked other than "natural", or Ites 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Idilor Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Finagin Chenste cotherine 19a. Informant's Name/Relationship Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny Injury or other trau QDCE. Place of Disposition (Name of competery, crematory or other place)

Date

Date

20c. Location - City or Town, State Goetz Jilliam 20a. Method of Disposition 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State Cemery Sept. 19 2015 Baltimose 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of R cility 5800 HERTORE RO Evans Charl of Memories Baltimera, mo 21734 23a. Part1. Enter the disease, or complications that caused the dilater. Shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. ettending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been significant page 2 should be 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2000 2 X No 1 ☐ Yes 1 Yes To the Hospitel or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 1 ☐ Yes 2 No 1 🗌 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 1 Yes 2 No death. investigation within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 1 aleer Seplember 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 560 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hydiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ranoate of Death	neg. New O
rtificate of Death	200 11
artificial of Ficaltif and W	lental Hygiene

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 _	_		~	_

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any highry or other treumatic event, the Medical Exeminar must be notified at once.

Baltimore, Maryland 21215-0036

James Cahan

Physician /Medical Examiner

the attending physician and thed for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be execu Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Funerel Director: A

To Be Completed by Funeral Director Medical Certification: To Be Completed by Physician/Medical Examiner 4 | Homicide 29a. Certifier

- State Registrar	Certificate of Death	Reg. N& UU 5	30456
1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
Tames P. Gahan	TR	September 17, 2	05 6:20 AM
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of De	
Good Samaritan Hospital	13/1/11/11/11/P	NA	
5, Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24 Hrs.		Birthplace (State or Foreign
216.20.30/10 10×M 20F 72	Yrs. Months Days Hours Min.	(Month, Day, Year)	Country) TRYLAND.
Usual Residence of Decedent		6-22-32 MA	HRYLAND.
	own or Location		10d. Inside City Limits
MD BALTIMORE	BALTIMORE		1 ☐ Yes 2 No
10e. Street and Number	10f. Zip Code	10g. Citizen of What	Country?
8710 811	21234.	115	Δ
o 110 cmge 10.		USI 14 Bass As	merican Indian,
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	Rican, etc.)	
1 Never Married 2 Married 1 ☐ Yes 2 No	1 ☐ Yes 2 No Specify:	Specify:	· h · 10
3 ☐ Widowed 4 ☐ Divorced Year or Dates:		U	SMIH.
15. Decedent's Education 16 (Specify only highest grade completed)	Sa. Decedent's Usual Occupation (Give kind of work done during most of work	ing 16b. Kind of Busines	ss/Industry
Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	0	51.
8	Store Gerk	brocer	y store.
17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maiden Surname)	1
Mass P. Cahan, SR.	Gene	vieve M. Sr	pioleu
19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street and Number or Run	al Route Number, City or Town, State	, Zip Code) 121095
Brandotto Hanlo.	12 Mandsingth P	Scidno Way 1	Whorville MI
20a. Method of Disposition 20b. Place		Date 20c. Location - City	or Town, State
1 Burial 2 Cremation 3 Removal from State	tery, crematory opother place)	21 05 5 1	11:11
*4 □Donation 5 □Other (Specify) EVAC	S FUNERAL CHAPEL- 14-6	11W. FOREST	HIL MO
21. Signature of Funeral Service Licensee	22. Name and Address of Facility 2-325	YORK RD. Timoniu	m MD 21093
Kinchely G. Saysothy	PEACEFUL ALTERNATIVE	S FUNCEAR ACREMI	4TION CENTER
23a. Part 1. Enter the disease, or/complications that caused the death. D shock, or heart failure. List only one cause on each line.	to not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
Immediate Cause (Final			Onset and Death
disease or condition resulting in death)			
Due to (or as a consequence	ce of):		
Sequentially list conditions, b.			
riany, leading to immediate Due to (or as a consequent cause. Enter Underlying Cause (Disease or injury	ce ot):		
that initiated events			
resulting in death) Last Due to (or as a consequence	ce of):		
d			
IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of c	delivery
23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death		Month	Day Year
1 Yes 2 No 9 Unknown			
Part II. Other significant conditions contributing to death but not resultin	n in the underlying cause given in Part I	23e. Did tobacco use contribute	to the cause of death?
4 1 4	g in the underlying cause given in and i.	/	
Coronary Artery Disease		1 √Yes 2 No 3	Probably 4 Unknown
Chronic obstructive Pulmone	in Disease	24a. Was an 24b. Were	autopsy findings available
	J	performed? death	
25 Was case referred to modical	00.00		es 2□No
25. Was case referred to medical examiner?	Other	h (Check only one)	
1 Tes 2 Pro	Outpatient 3 DOA 4 Indising no	ome 5 Residence 6 Other (S)	oecify)
27. Manner of Death 1 □ Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Date of Injury (Month, Day Year)	D. Time of linjury at Work?	28d. Describe how injury occurred	
2 Accident investigation	M 1 Yes 2 No		
3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	farm, street, factory, office	28f. Location (Street and Number or City or Town, State)	Rural Route Number,

State Registrar

29b. Signature and title of certifier

Haying Liang 31. Date filed (Month, Day, Year)

SEP 2 0 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

ORIGINAL

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Raven Bird, Baltimore, MD 21239

Res 000

			For State	State of Maryland			Mental Hygie	ne 2005	30457
		-	Registrar		Certifica	te of Death	Reg.	2.005	3. Time of Death
	Physicia /Medic		Decedent's Name (First, Middle, Last	S. 6	riffee			Day Year	
	Examin		4a. Facility Name (If not institution, give 900D SAMARITA			, Town, or Location of Dea		4c. County of Dea	ath
	Funeral			7. Age (In yrs. It	ast birthday) If Und	er 1 Year If Under 24 Hrs	8. Date of Birth	9. Bi	thplace (State or Foreign
	Director		01.1-18-4012	8M 20F 8	Yrs. Months	Days Hours Min	1-8-1924	MA	RYLAND
	yland Now		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
	Ba-f st	Director	MD BALTIC	PORE		i MORE		0:::	1 □ Yes 2 1 10
	3a or 2		262U Hiss A	Ivo.	101. 2	ip Code 21234	10g.	Citizen of What C	ountry?
	r death	Funerai	11. Marital Status	12. Was Decedent Ever in U.S Amped Forces?	S. 13. Was Dec	edent of Hispanic Origin? (Secrify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
920	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show avent, the Mudical Ezaira or must be inclined at	þ	1 Never Married 25 Married 3 Widowed 4 Divorced	1 MYes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify: U	phite.
21215-0036	72 hor	Completed	15. Decedent's Edu (Specify only highest grad		16a. Decedent's Us (Give kind of w	rork done during most of wo	rking 16t	. Kind of Busines	s/Industry
121	within iene.	отрі	Elementary/Secondary (0-12)	College (1-4or 5+)	Steo 1	(1)20100	1	MMCO	Steel
	be filed tal Hygi d other avant,	Be C	17. Father's Name (First, Middle, Last)	00		18. Mother's Na	me (First, Middle, Maid	den Surname)	
Maryland	Mer Mer ark	ဥ	19a, Informant's Name/Relationship (T)	ittee	19h Mailing Addres	as (Street and Number or R	Wal Boute Number of	Lec.	Zin Code)
	nd 2 aulth ar		Josephino Gi	iffer	3524 t	Liss Ave.	BALTIMO	RE M	021234
Baltimore,	Pages 1 and nent of Healt int: if item 2 iry or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	1 . 00	ace of Disposition (Nametery, crematory of	ame of other place)	Date 200	Location - City o	Town, State
İtim			4 Conation 5 ☐ Other (Specify) 21. Signature of Funeral Service Linus	16.0	LLOCO U	and Address of Facility	4-05 13	ALTIMO	SE MID
Ba	permit. Departr imports any inju		Springerly 4.	Zatholia	EVAO:	SFUNERALC		COHAK	
			23a. Part1. Enter the disease or/compleshock, or heart failure. List only o	ications that caused the death re cause on each line.	. Do not enter the mo	ode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Sepsio Due to (or as a consequ	ience of):				v 26 dougs
	Examiner		Sequentially list conditions,	Pancres	litis				1 month
E AV	nsit	Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	впса об.				
0,0	cate be executed bhysicien and the burial-transit		that initiated events resulting in death) Last	Due to (or as a consequ	ence of):				
8760,	cate be	dicai		1					
Вох 6	eath certific attending p I for use as I	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnar				23d. Date of de	livery
.O. B	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of de				Month	Day Year
P.	that the	by Phy	Part II. Other significant conditions con	ntributing to death but not resu	Iting in the underlying	cause given in Part I.	23e. Did tobacc	o use contribute t	o the cause of death?
ords	w requires been sign should be						1 ☐ Yes	2 (No 3 P	robably 4 Unknown
Vital Records,	elawr hasbe ye 2 sh	Completed					24a. Was an autopsy performed	24b. Were a prior to death?	utopsy findings available completion of cause of
		Φ	25. Was case referred to medical			26. Place of De	1 Yes 2 1 ath (Check only one)	No 1 ☐ Ye	s 2□ No
<u></u>	nysici nis cer direc	To B	examiner?	lospital: 1 npatient 2 E	ER/Outpatient 3 0	Other	lome 5 ☐ Residence	6 ☐Other (Spe	ecify)
ou of	tal or Attanding Ph s after death. Bi Diractor: After th ed in by the funeral		27. Manner of Death 1 ■ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of fnjury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
Division	Attan	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify	me, larm, street, lacto		28f. Location (Street City or Town, St	and Number or R	ural Route Number,
٥	pital or urs afte eral Dir illed in			1					()
	To the Hospital or Attanding Physician: within 24 hours after death: To the Functal Director: After this certific completely filled in by the funeral director.	ledical	29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	sician: To the best of my know ner: On the basis of examinati and manner stated.	vledge, death occurre- ion and/or investigatio	d at the time, date and place n, in my opinion, death occi	e, and due to the cause urred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	withir To th	M	29b. Signature and title ol certifier	. M.D.	2	Oc. License number	29d.	Date signed (Mon	th, Day, Year)
•	120.		30. Name and address of person who co		23a) (Type Print)	19443		16	2005
	1.7		JMDEEP HIN	70 RANT, 560	OL LOCK	RAUEN BLI	D. BAL	TIMORI	2 MI) 21237
			31. Date filed (Nonth Day Year)						

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GRIFFE

		1	For State Registrar	State of Maryland / D	Department of F Certificate of		ntal Hygien	711115	30458
*	Physicia /Medic	in al	1. Deceden's Name (First, Middle, Last)	a Gulbin			Date of Death	ay Year 2005	3. Time of Death
	Examin Funeral	3.	4a. Facility Name (If not institution, giversit	nter 7. Age (In yrs. last bin	Tou	If Under 24 Hrs. Hours Min.	B. Date of Birth	Baltin 9. Birth	NORE place (State or Foreign
	Director		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town			y-aa- /	7 1114	10d. Inside City Limits
ith the Mar	or 28a-f show sendified at	Director	10e. Street and Number	10RE	PARKVIII 10f. Zip Code	221	10g. C	itizen of What Cou	1 □ Yes 2 1 No intry?
5-0036 72 hours after death with the Maryland	l Health and Mental Hygiene Item 27 is marked other then "netural", or Itema 23e or 28e-f shov other traumatic event, the Mudical Examinational Canodilled at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hif Yes, specify Cubi	dispanic Origin? (Spec an, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Ameri Black, White, Specify: W	
	giene. er than "natural", the Medical Exe.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of working d)	D	Kind of Business/Ir	ore
Maryland	and Mental Hygiene. Is marked other than sumatic event, the Mi	To Be	17. Father's Name (First, Middle, Last)	erman		18. Mother's Name (lle Ma	clarte	<u>r.</u>
ore, M	0 .		19a. Informant's Na «Relationship (Typ) 20a. Method o Disposition 10 Buria 2 Cremation 3 Re	- daughter 10	Mailing Address (Street Disposition (Name of ry, crematory or other place)	brook Rd.	BALTIN	or Town, State, 21	D 212 34.
Baltimore,	Department o Importent: If sny Injury or once.		Donation 5 Other (Specify) 21. Signature of Funeral Service License	Garde	22. Name and Addre	ess of Facility BA	TIMORE,	sedale MD Zi: HARFORD	
Ph	ysician		23a. Part 1. Enter the disease, or complete shock, or heart failure. List only on Immediate Cause (Final disease or condition	ations that caused the death. Do	not enter the mode of dyin				Approximate Interval Between Onset and Death Locks
	Medical aminer		resulting in death) Sequentially list conditions, b.	Due to (or as a consequence	of):	0			
760, (v) te be executed	ysician and ne burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence					
ords, P.O. Box 687 requires that the death certificate	the attending phines as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 0 9 \(\text{Unknown} \)	Sc. II yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of deliv	very Day Year
ds, P.	signed 3 be de	þ	Part II. Other significant conditions continues the continues of the conti	tributing to death but not resulting in	/ /.			use contribute to	the cause of death?
I Recor	sete has been page 2 shouk	Completed	Artic Ster	nosis			24a. Was an autopsy performed?	prior to co	lopsy findings available ompletion of cause of 2 No
Division of Vital Records, or Attending Physician: The law requires t	ath. r: After this certificel e funeral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hammer of Death 1 Natural 5 Pending investigation		Time of 28c. Inju		(Check only one) e 5 Residence dd. Describe how inj	6 Dother (Special of the control of	in Hozrice
Divis al or Atte	s after death al Director: / ad in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, to building, etc. (Specify)	arm, street, factory, office	28	If. Location (Street a City or Town, Sta		al Route Number,
] Ine Hospital	within 24 hours after de To the Funeral Directo completely filled in by th	Medical	(Check only 2 Medical Examin one)	ician: To the best of my knowledger: On the basis of examination are and manner stated.	nd/or investigation, in my	opinion, death occurre	d at the time, date a	nd place, and due	to the cause(s)
, or	T E E	2	30. Name and address of person who con	y Rily un	D D D	se number	290. b	ate signed (Month)	n 16,2005
	M		30. Name and address of person who con	mpleted cause of death (Item 23a)	(Type, Print)	Chrles	St, Bala	to. Md	2120%
	Sta Regist		31. Date filed SEPP 2. You 2005	A STATE OF THE STA	Jane				

Designation Continued and provided Conti				Sta		nartment of Health and M	-	_	
Consider Name First Moths Last Consider September Consider Septemb				1 State Registrar				2005	30459
A COLON AND SECRET LA COLO	ľ		¥.				2. Date of Death		3. Time of Death
Examiner Common Service Common Common C				GERTRUDE	GAL	LLOWAY	6 m m m		8:20AM
Second Section Numbers College				tura .	and number)				
DELINEARING COLORS IN THE COUNTY IN THE COUN	**	*	के. व				TOWN		
June Bestimen or Decoders Tool. State Tool	Ï				d- (1)		Month, Day, Ye	ar) 9. Birthpli Count	
Bernary/Secondary 01 to 12 Coluge (1-4er 5-) The DOY On January The Doy On January Th		D	}		2 0		VAN. 15,	1911 100%	H CHROLINIA
Bernary/Secondary 01 to 12 Coluge (1-4er 5-) The DOY On January The Doy On January Th		anylar ehow	-	10a. State 10b. County	10c. City, Town or	B .	2 1 0	10	
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Temporary Temp	15-	in 72 i "nat	siete	(Specify only highest grade com	pleted) (Gir	cedent's Usual Occupation ve kind of work done during most of work . DO NOT use retired)	ing 16b	. Kind of Business/Ind	ustry
Temporary Temp	212	d with giene. r thar	mo		niege (1-4or 5+)		A .	SEI F-FY	n PLOVED
Temporary Temp		e file al Hyg I othe vent,							/-
20. Melgood of Disposition (Name of Date (Specify) Date	yla	ould b Ment arkec	To	BRITTON	WARR	EN LOLA	-R	MONTAL	BUE
20. Melgood of Disposition (Name of Date (Specify) Date	Mar	12 sh hand 7 lem traum							~
Comparison Com		1 and Healt em 2	1		20b. Place of Dis	DOSITION (Name of			
Provisiciant Medical Examiner Provisiciant Medical Examiner	non	ages ant of it: If it		1Æ Burial 2 ☐ Cremation 3 ☐ Remova			11 \ 5	1	1
Provisiciant Medical Examiner Provisiciant Medical Examiner	alti:								
23a. Part I. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory firest, shows or respiratory firest. Approximate the part of the death of th	ä	Deg in Se		Dietuch N.	William !	2140 N. FULTON	JAVE B	ALTO, MI	0.21217
Due to (or as a consequence of):	ľ.			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death. Do not e se on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
Due to (or as a consequence of): Sequentially list conditions cause. Finer Underlying cause. Finer Underlying resulting in death) Last Sequentially list conditions cause. Finer Underlying cause. Finer Underlying resulting in death) Last Sequentially list conditions cause. Finer Underlying cause of dealing. In Judge 12	H			disease or condition	Corscino	ma of le li	11011		Onset and Death
Part Line	1			resulting in death)	Due to (or as a consequence of):	1			
State State		1000	e	if any leading to immediate	Due to (or as a consequence of):	CAN 11/200	250		
State	1	uted d ansit	min	cause. Enter Underlying Cause (Disease or injury				4	
The state of the s	0,	e exection and an arrial-tr			Due to (or as a consequence of):				
We show a decoded the pregnant in the past 12 months? I cause of dealth? I cause of dealt	876	* > 9		d					
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Composition of completion of cause of death of the completion of the completion of the cause of death of the completion of cause of death of the completion of the completion of the cause of death of the completion of the completion of the completion of the completion of the completion of the completion of the compl	Bo	eath a atten I for u	cian	in the past 12 months?	Live birth 2 Fetal death 3				· I
Composition of completion of cause of death of the completion of the completion of the cause of death of the completion of cause of death of the completion of the completion of the cause of death of the completion of the completion of the completion of the completion of the completion of the completion of the compl	Ö.	t the c by the ached	hysi	TU TES ZUINO					
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1		ss tha	by P	Part II. Other significant conditions contribution	ng to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the	cause of death?
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1	ord	equire sen si	ted	LOCI MO NOT TO	74(07)		1 ☐ Yes	2	bly 4 □Unknown
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OFD 9 0 2005	3	Sta	10	1 0 10 (82. Registrar's Signatura	X J J J L L S O O	DK, KO	BERT KRO	OPNICK
					They are the page		-		

State

Registrar

THE WORE Mike 31. Date liled (Month, Day, Year)

Les

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

September 17, 2005

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

			. 101	irtment of Health and Mental Hygiene tificate of Death Reg. N 2 0 0 5 3 0 4 6 1
			Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
	Physicia /Medic		Charles T. Grimes, Jr.	September 16, 2005 5:05 P M
,	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
ı		١,	202 Kimary Ct., Unit 2B 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Forest Hill Harford Harford Grate or Foreign 9 Birtholage (State or Foreign 9 Birtholage
	Funeral Director		220-18-6828 1 M 2 F 77 77 77 77 77 77 7	If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 9. Birthplace (State or Foreign Months Days Hours Min. 0ct. 6, 1927 Maryland
			Usual Residence of Decedent	
	urylan show	_	10a. State 10b. County 10c. City, Town or Loc	1 CVc offine
	Ba-f s	Director	Maryland Harford	FUZEST TILL
	death with the Maryland ms 23a or 28a-f show Frints Let Fulffe J.Ef	Ö	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	ns 23	Funerai	202 Kimary Ct., Unit 2B 11. Marital Status 12. Was Decedent Ever in U.S. 13. W	Vas Decedent of Hispanic Origin? (Specify Yes or No- Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
o	after death with the Marylan or Items 23a or 28a-f show infrest met Le modified at	F	Armed Forces? If 1 □ Never Married 2 (1) Married 1 (1) Yes 2 □ No If Yes 6 (1) Yes 7 □ No	Type 2M No. Specific
-U030	illed within 72 hours after de Hygiene. ther then "naturel", or Items int, I'es Medical Examirer in	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	white
<u>ה</u>	n 72 hours "naturel", edicel Exe	ompieted	(Specify only highest grade completed) (Give I	ent's Usual Occupation ent's Usual Occupation 16b. Kind of Business/Industry kind of work done during most of working ONOT use retired)
7	withi iene. then	omp	Elementary/Secondary (0-12) College (1-4or 5+)	Accountant Utility Company
ם פ	e filed of heg other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Jai	wuld by Menta arked	ToE	Charles T. Grimes	Laura S. Stolarski
Jan	2 sho and Is ma			g Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ຍົ	is 1 and 2 should of Health and Mer item 27 Is marke other traumatic			imary Ct. Unite 2B, Forest Hill, Md. 21050 Date 20c. Location - City or Town, State
	ages int of I t: If its		1 ☐ Burial 2 【Cremation 3 ☐ Removal from State cemetery, crem	
paltimo	nit. Plartme ortan injur		20070.000	rematory! Baltimore, Maryland Name and Address of Facility Schimunek Funeral Homes
ă	Depa Impo eny i			705 Belair Rd., Baltimore, Maryland 21236
			23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.	Interval Between
	Physician	l li	Immediate Cause (Final disease or condition a Metastatic	Blacker Cancer grunning
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	
		e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	
Ś	an an		resulting in death) Last Due to (or as a consequence of):	
00/0	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	licai	d	
Ď X O	he death certifica the attending phi ched for use as th	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy	and Date of delivery
0	atten for us	cian	23b. Was decedent pregnant in the past 12 months? 1	Ectopic pregnancy 23d. Date of delivery Other (specify) Month Day Year
j.	the d by the ached	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown	
7	v requires that the de been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
cords	v require been sig should b			1 Tes 2 No 3 Probably 4 Unknown
S	law r nas be	ompieted		24a. Was an autopsy findings available prior to completion of cause of
E	ician: The lav certificate has rector, page 2	O		performed? death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
VICAL		o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death (Check only one)
5	ding Phys h. After this funeral di	⊢ :	27. Manner of Death 28a. Date of Injury 28b. Time of	3 □ DOA □ Other: 4 □ Nursing Home 5 ☐ Aesidence 6 □ Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred
VISION	tending Jeath. tor: Afte the fun	atio	1 SNatural 5 Pending (Month, Day Year) Injury 2 Accident investigation	M 1 Yes 2 No
2	r Atterdering the dering the color of the co	ertification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
2	pitel c	O	29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death	
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	dicai	29a. Certifier The certifying Physicien: To the basis of my knowledge, death (Check only one) 2 Medical Exeminer: On the basis of examination and/or invented in the certifying Physicien: To the basis of my knowledge, death one) 1 1 1 1 1 1 1 1 1	occurred at the time, date and place, and due to the cause(s) and manner as stated. estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To the within To the complex	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
	×		· /n.v.	W45370 September 19, 2005
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, F	045390 September 19, 2005 Atword Road # 200, Bel Air, MD21014
	Sta	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature	
	Registr	26	SEP 2 0 2005 Report 15 South	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 23a, PtI, II per Br. 16347,09/20105dhb

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** September 4, 2005 Mary Grote Thelma /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Catonsville Baltimore Charlestown Nursing Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F 98 214-01-4133 Director March 23,1907 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "neturel; or items 23a or 28a-f show treumatic event, the Madical Examination must be indiffed at 1 ☐ Yes 2 🔀 No Director Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1729 Pine Forest Court 21014 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. ð 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry De filed wit.
**I Hygiene.
**ser then "p Elementary/Secondary (0-12) College (1-4or 5+) Steno_ Pool Manager State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) h and Mental I F. Duvall Walter J. Yinger Emma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ages 1 and 2 so to of Health an: If item 27 is a 1729 Pine Forest Court Bel Air, Maryland Barbara M. Haines Daughter 21014 other t Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 permit. Page Department c Importent: If any injury or once. ö 21. anature of Fin val Sevice Licensee Moreland Mem. Park 9-10-2005 Parkville 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Road Towson, Maryland 21204 Inc. 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Arteriosclerotic Cardiovascular Disease Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Years Bowel obstruction /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed physician ar Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached for o. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, by Bowel Obstruction 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s certificate has autopsy performe 1□ Yes → No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death P o this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 Natural
2 Accident 5 Pending investigation 1 Yes 2 No death. **Director:** 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c License number

State Registrar Zein

2 0 2005

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ORIGINAL

ath (Item 23a) (Type, Print)

h, Day, Year 32. Registrar's Signature

030989

711 Maiden Choice Ln Catoroville MD

September 04 2005

			For State Registrar	State of M	aryland		artment of rtificate of			F	Reg. N2 0 (05	30463
	Physicia	an	1. Decedent's Name (First, Middle, La							2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic		George Richa		1		4b. City, Town,	or Logation		Septemb	er 14,	2005	11:25 P ^M
<i>F</i>	Examin	er	4a. Facility Name (If not institution, giv		Conto	r		Air	or Death			ford	
	Francis		Upper Chesapeake			ast birthday)	If Under 1 Yea	r If Under		8. Date of Birt	h		lace (State or Foreign
	Funeral Director			1 ⊠ M 2□F	85	Yrs.	Months Days	Hours	Min.	(Month, Da) July 22	1920		Virginia
	P .		Usual Residence of Decedent 10a. State 10b. County		10c City	r, Town or Lo	cation					1	Od. Inside City Limits
	r 28a-f show	7											1 ☐ Yes 2 ☐ XNo
	the M	Director	Maryland Harford 10e. Street and Number		Fa	illsto	10f. Zip Code				10g. Citizen of V	Vhat Coun	itry?
	with be or		1323 Murgatro	vd Road			210	47			U	SA	
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	S. 13.	Was Decedent of		rigin? (Spec	city Yes or No-			an Indian,
٥	or Ite	Fur	1 Never Married 2 Married	1 ⊠Yes 2 ☐	No		1 ☐ Yes 2 🔯 No			110011, 0101,	Specify	,.	
215-0036	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show sefred Examinational be notified at	d by	3 NWidowed 4 □ Divorced	Year or Dates:						1	16b. Kind of Bu	V	White
2	hin 72 ho a. "natul Medical	Completed	15. Decedent's E (Specify only highest gr.	ade completed)		(Give	dent's Usual Occi kind of work don DO NOT use retir	e durina mos	st of workin	g	16b. Kirid of Bu	12111622/1110	Justry
7	E the wit	ошр	Elementary/Secondary (0-12)	College (1-4or	5+)	Engi	neer				Railro	ad	
0	illed Hygi other ent,	Be C	17. Father's Name (First, Middle, Last)				18. Moth	er's Name	(First, Middle,	Maiden Sumam	10)	
yland	ould be Mentat parked o	To B	Harry (nmn)	Gosnell				Emn	na (r	nmn) W	ann		
Mary	and and sun		19a. Informant's Name/Relationship (ng Address (Stree	et and Numb	er or Rural	Route Numbe	r, City or Town,	State, Zip	Code)
	1 and 2 Health tem 27 i		Mariann J. Umste	ad / Grand			1323 Mur	gatroy		ad, Fal	lston,		
O.	Pages 1 nent of H int: If ite iry or otl		20a. Method of Disposition 1 Durial 2 Cremation 3 D	Removal from State	C	emetery, cre	matory or other p						Maryland
Baltimore,	permit. Pag Department Important: any injury o		4 Densition 5 Other (Special States) Services (Special States)		Bal		Nat'l					ore,	Maryrand
Ra	permit. Pages Department of Important: If it any injury or o		21. Signature of Friting Toxyco y co	1-1111	MA		Name and Add					T .	21000
			23a. Part Prints the disease or con	mplications that cause	d the death	n. Do not en	ter the mode of d	espury ving, such as	ROAC s cardiac or	respiratory ar	gaon, M rest,	aryıc	and 21009 Approximate Interval Between
	Dhaalalaa		Shock, or heart failure. List only one cause on each line. Onset and Deliminediate Cause (Final									Onset and Death	
	Physician /Medical		dispase or condition resulting in death)	a Due to (or as	BKO V a consequ	JASCU uence of):	CAR I	4 CCI D	ENT				
	Examiner			b									
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C									
760,	te be executed ysician and te burial-transit	al Ex	logotting in douthy East	D00 t0 (01 as	a consequ	derice or,.							
20	e % e	dical	•	d									
ox e	leath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Dat	e of delive	ery
m	death a atter d for u	iciar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			☐Ectopic pregnan ☐ Other (specify)	су			Mo	nth	Day Year
oj.	t the c by the	hys	9 Unknown	9□ Unknown									
S,	uires that the dessigned by the a	by P	Part II. Other significant conditions			1		oven in Part	1.		20		ne cause of death?
ğ	w require been sig	ted	RENAL FAILU	- 4						101			
Records,	law ras be	Completed	ARTERIOSC LEROI	TIC CARDI	OVAS	CULA	R DISE	ASE		24a. Was autop	SV	Were auto prior to con death?	psy findings available mpletion of cause of
	ding Physician: The lav h. After this certificate has funeral director, page 2	Con								1 ☐ Yes		Yes	2 No
Vita	ician: cartific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Man		(Check only o			
ot	Phys this ral dir	- 10	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 28a. Date of Inj		ER/Outpatie 28b. Time of	IL SU DOA	4 🗆 14			dence 6 Oth		y)
O	ding h. After fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, D.	ay Year)	Injury		'onk? ∐Yes 2.[]No				
Division of Vital	Atten r deal sctor: by the	ifica	3 Suicide 6 Could not I	280. Place of it	njury - At ho	ome, farm, st	reet, factory, offic	9	2	18f. Location (S City or Tox		er or Rura	Al Route Number,
á	al or a after	Certification:	4 Homicide	Building, e	tc." (Specify	y)				Only or row	m, otatoj		
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the		(Check only 2 Medical Exe	hysicien: To the bes	of examina	wledge, deat tion and/or in	th occurred at the	time, date a	nd place, a ath occurre	nd due to the	cause(s) and ma date and place,	inner as st and due to	tated. the cause(s)
	the hin 2 the I	Medical	29b. Signature and title of certifier	and manner s	tated.		29c. Lice	nse number			29d. Date signe	d (Month,	Day, Year)
)	T wil		The same	Mark	n	λ		4534	U		09/15		
	1		30. Name and address of person who	completed cause of	death (Item	n 23a) (Type	Print)						
in	117			IT AWI, MC	,62	25,0%	10 a AVE	. 1144	REde	- GRACI	= MD	2/07	8
W	St	ate	31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	iture	0. 0	,			/		
	Regist	rar	SEP 2 0	2005	1.18 2	14 6	per						

State of Maryland / Department of Health and Mental Hygie 1205 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month De Dav Vage **Physician** 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death **Examiner** SOLTIMON REDICA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Mumber 6. Sex **Funeral** 1 □ M 2 X XF Yrs 213-26-8901 AUGUST 11 MARYLAND Director 1928 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Hygiene. other than "natural", or items 23e or 28a-f show ont, the Modical Examinational be notified at 1 Yes 2 □ No Director BALTIMORE MARYLAND N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1513 N PAYSON STREET 21217 U.S.A. filed within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) WESTINGHOUSE ELECTRICAL WORKER 12th grade other 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H is marked of NETTIE HICKS THOMAS 2 GEORGE THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: if itam 27 is any injury or other trace 1111 Park Avenue #201, Baltimore, Md., 21201 Deborah Hclly/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 09-19-05 `4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY BALTIMORE, MARYLAND 21. Signature 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final XNONIC KESPIN Physician disease or condition resulting in death) /Medical Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit MANONO Due to (or as a consequence of) attending physician for use as the burial Physician/Medicai Box IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 99 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed page 2 🗆 No 1 ☐ Yas 1 Yes 2/2/No Division of Vital To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital: 1 ☐ Yes 2 ☐ No 27. Manner of eath Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 this Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 | Homicide n 24 hours a To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2 To tha 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier numerono and address of person who completed cause of death (Item 23a) (Type, Print) mo 300 lin BONACUM 32. Begistrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 0 2005 Registrar

			For State Registrar	tate of Maryland	d / Department of Certificate	of Health and No	Mental Hygiei		30465	
	Physici		1. Decedent's Name (First, Middle, Last) FCCCCC	. T	Hacho	Sa	2. Date of Death	Day Year	3. Time of Death	
9.0 #	/Medic Examin	er	4a. Facility Name (If not institution, give stre 83 22 Over mont 5. Social Security Number 6. Sex	et and number) 7. Age (In yrs. la	ast birthday) If Under 1 Y			4c. County of Death BACT 9. Birth		
2	Funeral Director	}		2 ☐ F	Yrs. Months D	ays Hours Min.	8. Date of Birth (Month, Day, Ye 2 - 19 - 2	8 MA	LYLANO 10d. Inside City Limits	
	th the Mary or 28a-1 eho	Director	MD BATIMO	et	BALTIN 101. Zip Co		10g.	Citizen of What Co	1 □ Yes 2 No untry?	
36	72 hours after death with the Maryland natural', or Reme 23a or 28a-1 ehow jicel Examinar must be natified at	by Funeral D	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	H Kd., Was Decedent Ever in U.S Amped Forces? 1 [I] Yes 2 □ No If Yes, Give Year or Dates:	5. 13. Was Decedent If Yes, specify	21234 of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Amer Black, White		
21215-0036	within ene. then	Completed b	15. Decedent's Educati (Specify only highest grade of	on	16a. Decedent's Usual O (Give kind of work d life. DO NOT use n	one during most of won	16b	Kind of Business/	industry	
Maryland 2	should be filed ind Mental Hygid marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type,	Hoehn	19b. Mailing Address (Si	Creso	e (First, Middle, Maio Centa Cal Boute Number Ci	Wenge	DR Code)	
Baltimore, Ma	of Health ar of Health ar if Item 27 is or other trau		20a. Mathod of Disposition 1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	8322 OVE ace of Disposition (Name imetery, crematory or August	rmont R	Date 200		MD 21234	
Balti	permit. Pag Department Importent: any injury c		21. Signature of Funeral Service Licensee	Zawa tala	22. Name and A	UNERALC	TIMORE,		ORD RP.	
	Physician physician end physic		23a. Part . Enter the disease, dr complicat shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	M. t	Interval Be groset and				
8760,		dicai Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a consequ	/				N-1001 \
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician end page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnant 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 Ectopic pregr			23d. Date of deli Month	very Day Year	
	w requires that been signed b should be deta	ρ	Part II. Other significant conditions contril	outing to death but not resu	Iting in the underlying caus	se given in Part I.	23e. Did tobacc		the cause of death?	
of Vital Records,		Completed					24a. Was an autopsy performed	death?	topsy findings available completion of cause of	
Vit	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	pital:		Othor	th (Check only one)			
ion of	Attending Physic death.	ıtlon: To		TO THE ZE NO	1 ☐ Inpatient 2 ☐ E 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 DOA 28b. Time of Injury M	Injury at Work? 1 Yes 2 No	ome 5M Residence 28d. Describe how i	e 6 □ Other (Spec njury occurred	oify)
Division	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	a Could not be	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory, o	ffice	28f. Location (Stree City or Town, S		iral Route Number,	
	To the Hospitel or within 24 hours affect to the Funerel Directions completely filled in I	edicai	(Check only 2 Medical Examiner one)	an: To the best of my know On the basis of examinat and manner stafed.	on and/or investigation, in	my opinion, death occu	rred at the time, date	and place, and due	to the cause(s)	
	To the To the Comple	Σ	29b. Signature and title of certifier		29. 1	4273	6	Date signed (Monti	-05	
	1041		30. Name and springs of person and com	760c	23a) (Type, Print)	Drive	- 10	Wan	21204	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	39. Registrar's Signal	Control of the second					

State of Maryland / Department of Health and Mental Hygie 20 0 5 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day /Medical PHEMBER alo 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 405PITA ahrus ar If Under 24 Hrs. N/A Social Security Number **Funeral** 7. Age (In yrs. last birthday Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Months Hours 1 □ M 2 X F Director 055 34 0848 Yrs 3/11/1941 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is markad othar than "naturat", or Itams 23s or 28a-f show any injury or othar traumatic evant, the Medical Examiner must be recitifed and 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2737 Westminster Road Completed by Funeral 21043 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert S. Vroman 2 Geraldine Coons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Preston Hartmann/husband 2737 Westminster Rd. Ellicott City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 9/20/2005 Catonsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHarry H. Witzkes' Family FH, Inc. 4112 Old Columbia Pk. Ellicott City, MD 21043 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a NOW - SMALL months disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Day 4☐Pregnant at time of death Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ρ PNEUMONIA 1. Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1€Inpatient 2 ER/Outpatient 3 DOA in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To tha Funaral I 1 certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number RES-000 September 18 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAHIMOLE, MANY AND 21387 4. Wafe HOLDHOFF 600 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SET 2 0 ZUUD Registrar

			1 - For State Registrar	State of M	aryland		artment <i>rtificate</i>					giene 0	05	30467
	Division		1. Decedent's Name (First, Middle	e, Last)							2. Date of De	ath		3. Time of Death
	Physic /Medi		Eugene	Norgar	-d	Ha	nser	Ī		45	Month	ca 16	200	5-5:15 PM
	Exami	ner	4a. Fecility Name (If not institution				4b. City, To				, , , , ,	4c. Cou	nty of Deat	h
9			Kni Versity of			Spitul			alt	MO				
	Funeral Director		5. Social Security Number 219–18–6090	6. Sex 7. Ag	je (In yrs. la 83	ist <i>birthd</i> ay) Yrs.	If Under 1 Months	Year Days	If Under Hours	Min.	8. Date of Birt (Month, Da	, Year) 1922	9. Birt	hplace (State or Foreign
			Usual Residence of Decedent		0.5	713.				11	1ay 1/	, 1922	. Geo	orgia
	show		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	e-fs	ctor	Maryland Balti	more		Cato	onsvil	le						1 ☐ Yes 2 ☐ No
	or 28	Directo	10e. Street and Number				10f. Zip C	ode				10g. Citizen o	of What Co	untry?
	ours after death with the Maryla ral', or Items 23a or 28e-1 shov Examinate must be multified at	ra	903 Vanderwo	ood Road				2122	28			U	JSA	
	er de Items	Funeral	11. Marital Status	12. Was Decedent Amed Forces?	4.0		Was Deceder	nt of His Cubar	spanic Origin, Mexican	gin? (Spec n, Puerto R	ify Yes or No- ican, etc.)	14. P	lace - Ame	rican Indian,
36	rs aft	by F	1 ☐ Never Married 2 💢 Marri 3 ☐ Widowed 4 ☐ Divorced	ried 1 X Yes 2 □ I If Yes, Give Year or Dates:	№ 194 194	42	1 □ Yes 2		Specify:				city: Whi	
21215-0036	within 72 hours after death with the Maryland ene. than "netural; or Items 23a or 28e-1 show the Madical Exerciter was be retitlified at	edt		t's Education	17.		dent's Usual	Occupa	tion			16b. Kind of		
215	77 nin n ne Mediti	Completed	(Specify only highe	st grade completed)		(Give	kind of work DO NOT use	done d	uring most	t of working	9	100. Kirid of	DUSINGSSA	industry
212	filed within Hygiene. other than	E O	Elementary/Secondary (0-12)	College (1-4or 5	0+)	Sal	Les					Food	Indus	stry
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yla	should be id Mental marked o matic eve	2	Hans Carl Hanse	en					C	harlo	tte A.	Norga	rd	
Maryland	and and sm		19a. Informant's Name/Relations								Route Numbe			
	1 and 2 Health tem 27 l	1	Dorothy W. Hans	sen, Wife	100	903 7	lander v	VOOC	l Road			le, Ma	rylan	d 2 <u>1228</u>
O.	Pages hent of H		20a. Method of Disposition 1 □ Burial 2 X Cremation	3 Removal from State	COL	metery, cren	sition (Name natory or othe	ar place		Da		20c. Location	-	
Baltimore,	t. Pa rtmen rtant;	1 74	' 4 ☐ Donation 5 ☐ Other (S	pecify)	Meti		ematory		1		/05	Balti	more,	Maryland
Ba	permit. Pages 1 and Department of Healt Important: If item 2 eny injury or other once.		21. Signature of Funeral Service Thomas Greg	gor		5	remati	lon eder	Socie ick I	ety O Road	f Mary Baltim	land I	nc. aryla	nd 21228
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lin	I the death. ne.	Do not ent	er the mode of	of dying	, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
	nysician	i ji	Immediate Cause (Final disease or condition resulting in death)	-a acute	m	400	ardie	u	ingo	with	on		- 1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	onco of):			U					The state of the s
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8760	cate be executed physician and the burial-transit			d										
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Вох	death certifica e attending ph id for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			Ectopic preg					23d. D	ate of deliv	very
E		sicis	in the past 12 months? 1 Yes 2 No	4☐ Pregnant at			Other (speci					٨	Month	Day Year
P.O.	that the d ed by the detached	Phy	9 ☐ Unknown											
	ngi De	by	Part II. Other significant condition		ut not result	ing in the ur	iderlying caus	se giver	n in Part I.					the cause of death?
oro	v requir	sted	polycythe	m/4.							1 🗆 Y	es 2 No	3 ☐ Pro	babiy 4 Unknown
ec	aw as b 2 s.	ompleted									24a. Was a autops	SV	. Were auto	opsy findings available
a	Th ate pag	Co									perform	med? 2D No	death?	2 No
Vital Records,	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:							Check only or			
o	Phys rthis ral di	. To	1 res 2 No 27. Manner of Death	1 ☐ Inpatie		Outpatient 8b. Time of		Other Injury	4 [] (Vul:		me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			fy)
on	iding Phy th. After thi funeral	tion	1 Natural 5 Pending	g (Month, Day	Year)	Injury	М	Work?	es 2.⊟N		u. Describe no	ow injury occu	rred	
Division	Attending ir death. ector: After by the fune	Certification:	3 ☐ Suicide 6 ☐ Could r	ot be 28e. Place of Inju	ıry - At hom	e, farm, stre				-	Location (Si	reet and Num	ther or Rur	al Route Number,
á	al or	ert	4 Homicide	building, etc	. (Specify)		,,,, .				City or Towi	n, State)	0. 0. 7 (0)	ar riodio romocr,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical (29a. Certifier 1 Certifyin (Check only 2 Medical I	g Physician: To the best of	of my knowle	edge, death	occurred at t	he time	, date and	l place, and	d due to the ca	ause(s) and m	nanner as s	stated.
	the h	Medi	one) 29b. Signature and title of certifier	and manner sta	ted.		estigation, in	niy opii	mon, dean		at the time, o	ate and place	, and due t	o the cause(s)
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	25"		Marcia A Cot	who completed cause of de	atn (Item 2	Ja) (Type, F	rint)	10.1	100		7.5 6	6	_4.	MD 21201
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	Registr	ar	SEP 2 (2005	~ B	e So	galle D							

			For State Registrar	State of Ma	-	artment of F rtificate of		nd Mental Hy		30468			
**	Physici		1. Decedent's Name (First, Middle, Last) George Wilfrid					2. Date of Dea	Day Year	3. Time of Death			
	/Medic Examir								4c. County of Death				
歌	Funeral Director		5. Social Security Number 6. Sep 210-09-7274 Usual Residence of Decedent	7. Age XM 2□F	(In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of Birt (Month, Da March 2	76,1921 Pennsy	e (State or Foreign Vlvania			
Maryland 21215-0036	Maryland e-f show	ctor	10a. State 10b. County Maryland Baltimon			10d.	. Inside City Limits 1 Yes 2 No						
	with the	Dire	10e. Street and Number 21228						10g. Citizen of What Country USA	?			
	d within 72 hours after death with the Maryland jene. Ir than "natural", or tema 23a or 28a-f show the Modical Examinational te multing at	by Funeral Director		12. Was Decedent Et Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:	1941			in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Black, White, etc	14. Race - American Indian, Black, White, etc.			
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land	s t and 2 should be filed of Heelth and Mental Hygi Item 27 is marked other other traumatic event, II	To Be (17. Father's Name (First, Middle, Last) George John Hipp					's _{Name (First, Middle,} nerine Abel					
	nd 2 should sith and Mer 27 is mark r traumatic		19a. Informant's Name/Relationship (Ty Margaret M. Hipp,						or, City or Town, State, Zip Co Maryland 212				
altimore,	Pages 1 and 3 nent of Heelth int: If Item 27 iry or other tra	ľ	20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ R			matory or other pla		Date /16/05	20c. Location - City or Town Baltimore, Ma				
Baltir	permit. Pages Department of Important: If I any injury or once.		Metro Crematory Inc. 9/16/05 Baltimore, Maryland 21. Signature of Funeral Service Ucensee Thomas Gregor Metro Crematory Inc. 9/16/05 Baltimore, Maryland 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228										
	death certificate be executed We attending physicien and tor use as the burial-transit	ed by Physician/Medical Examiner	23a. Part1. Enter the disease, or complishock, or heaf tailure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):	Arta unin f	-	-	ln.	pproximate terval Between nset and Death			
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rds, P	law requires that the as been signed by th 2 should be detache					Part II. Other significant conditions cor	ntnbuting to death but	not resulting in the u	nderlying cause giv	en in Part I.		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknow	
Vital Records,	The ate h page	Completed	Complete						24a. Was an autopsy findings availab prior to completion of cause of death? 1				
Vita	Physician: Th this certilicate ral director, pag	To Be	25. Was case referred to edical examiner?	lospital: Inpatient	t 2 🗆 ER/Outpatier	nt 3 DOA Oth	05	of Death Check only or	ence 6 Other (Specify)				
ion of	ing After une		27. Manne eath 1 atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Time o	f 28c. Injur Wor		28d. Describe h	ow injury occurred				
Division	tel or Attend s after death el Director: / ed in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, sti (Specify)	eet, factory, office		28f. Location (S City or Tow	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospitel within 24 hours a To the Funerel Completely filled	edical	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Examination	sician: To the best of ner: On the basis of e and manner state	examination and/or in	h occurred at the tir vestigation, in my o	ne, date and pinion, death	place, and due to the of occurred at the time, o	cause(s) and manner as state date and place, and due to the	ed. e cause(s)			
)	To T To T	Σ	29b. Signature and title of certifier	le .		29c. Licens	e number	0415	29d. Date signed (Month, Day	y, Year)			
	5X1		30. Name and address of berson who co	empleted sause of dea	ath (Item 23a) (Type,	Print)	hin	Mount	1 Husia	1			
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 0 200	32 Registrar	's Signature	sole)		<i>p</i> - <i>ccs</i> -100/	V) - Yrey				

			State of Many						•
			1- For State of Mary Registrar		artment of t rtificate of			7005	30469
			Decedent's Name (First, Middle, Last)			Dealli	2. Date of Dea	-	
	Physic /Medi		CARROLL HILTI	YER	-		Month	tember 15	
	Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of Deat		4c. County of De	
			NORTHWEST HOSPITY 5. Social Security Number 6. Sex 7. Age //n	t-L	If Under 1 Year	ALLST (NWC	BALT	IMORE
	Funeral Director		220-52-3576	yrs. last birthday) 56 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day Sept. 3	y, Year)	irthplace (State or Foreign Country) ryland
	pur		Usual Residence of Decedent 10a. State 10b. County 10c	01. 7			вере. Э	0,1540 Ma	1 y 1 and
	Maryla f sho	ō	Maryland Baltimore	C - t					10d. Inside City Limits 1 ☐ Yes 2X No
	r 28a-	Director	10e. Street and Number	Caloi	10f. Zip Code			10g. Citizen of What	
	23e o	ai D	8 N. Prospect Avenue		2122	.8		U.S.A.	
	er dea	une	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		nerican Indian,
36	irs aft	by Funerai	1 ☐ Never Married 2 【X Married 1 ☐ Yes 2 【X No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes 2 ☑ No		,	Specific	
Maryland 21215-0036	d within 72 hours after death with the Maryland giene r than "naturel", or Items 23e or 28a-f show Tre Medical Examiner must be notified at		15. Decedent's Education		dent's Usual Occup			16b. Kind of Busines	hite s/industry
21	within ene. than "r	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life.	KIND of work done DO NOT use retired	during most of wor d)	king		,
d 2	ified w Hygie other ti		17. Father's Name (First, Middle, Last)	Juven	ile Just	ice Moni			ustice Syster
lan	be d la la la la la la la la la la la la la	To Be	Carroll Pensmith Hiltner			June Ka		Maiden Surname)	
ary	2 should and Men is marka eumatic	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street			r, City or Town, State	Zin Code)
	127 B B		Barbara Hiltner (Wife)	8 N.	Prospect			11e, MD 21	
Baltimore,			1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	 b. Place of Dispo cemetery, cren 	sition (Name of matory or other plac	се)	Date	20c. Location - City of	r Town, State
莊	- E E E	. %	' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses	hesapeak	e Cremat	ory 9-26	5-2005	Beltsville	, Maryland
Ba	Dep Impo any ir		Will the the	A Wi	tzke Fun	eral Home	of Cato	onsville,	Inc.
	-		23a. Part1. Enter the disease, or complications that caused the c shock, or heart failure. List only one cause on each line.	/ 10	SO Edition	uson ave.	Caronsy	77 II e. Mar	yland 21228 Approximate
ı	Physician		Immediate Cause (Final disease or condition	TIDN	PNE	UNION	114		Interval Between Onset and Death
	/Medical Examiner		resulting in death) a. Due to (or as a con				411		40 01 =
1		- G	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		ISORD	ER			DHYS
P	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	sequence or).					
o,	te be executed ysician and ie burial-transit	Еха	resulting in death) Last	sequence of):					
8760,	flicate be executed g physician and as the burial-transit	dical	d						
89 x	ding p	Physician/Med	IF FEMALE: 23c. If yes, outcome of pre	GD 2 D C V					
Вох	death s atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 4 Pregnant at time of	etal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
О. О.	at the by the tacher	hys	9 ☐ Unknown 9 ☐ Unknown						
s,	To the Hospital or Attending Physicien: The law requires that the death certifica within 24 hours after death. within 24 hours after death. completely filled Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	by F	Part II. Other significant conditions contributing to death but not		derlying cause give	en in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
Record	w requir been si should	Completed by	HUMAN IMMUNODEFI	CIEN	- (12		1 □ Ye	s 2□No 3□P	robably 4 XUnknown
Rec	hast ge 2 s	mpi	SYNDROME				24a. Was ar autops	y prior to	utopsy findings available completion of cause of
Vita	en: Th		25. Was case referred to medical				perfórm 1 ☐ Yes 2	No 1 ☐ Yes	2 □ No
<u>=</u>	ding Physicien: The lav h. After this certificate has funeral director, page 2	To Be	examiner?	: ☐ ER/Outpatient	3□ DOA Othe	26. Place of Deat		e) nce 6 □Other (Spe	off d
Division of	ng Ph fter th ineral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year,	28b. Time of	28c. Injury Work	at	28d. Describe ho		City)
Sio	ttendi death. tor: A the fu	cati	2 Accident investigation		M 1 🗆 1	Yes 2 □ No			
<u>></u>	l or A after Direc	Certification:	4 Homicide determined 28e. Place of Injury - A building, etc. (Spe	: home, farm, stre icify)	et, factory, office		28f. Location (Str City or Town	reet and Number or R , State)	ural Route Number,
	To the Hospital or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the		29a. Certifier (Check only Check only 2 Medical Examiner: On the best of my second	nowledge, death	occurred at the tim	e, date and place.	and due to the ca	use(s) and manner as	stated
	the Hin 24 the Fu	ledical	one) and manner stated.	nation and/or inve	estigation, in my op	pinion, death occurr	ed at the time, da	te and place, and due	to the cause(s)
	Vitt Con	Σ	29b. Signature and title of certifier	1 1 0	29c. License	number	29	d. Date signed (Mont	
	/		Thustine Kajuh Hospi	talut	620	112	5	ptember	15 2005
	しつ		30. Name and add ss of person who completed the e of d ath (II)	em 23a) (Type, P	Print) PILAI XDI	ISTOM	111 11	ARYLAN	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Sig	inature	PTIV INFI		41471411	IN I CFU	
-	Registra	ar	SEP 2 0 2005	A Soo	a Steel				

			For State Registrar	State of Maryl	and / Depa	artment of H	lealth and Death	Mental Hyg	giene 200	15 30470
	Physici		1. Decedent's Name (First, Middle,	Adolph	Hockha1	ter		2. Date of Dea Month		3. Time of Death 8:45 P. M
	/Medic Examin		4a. Facility Name (If not institution, g	give street and number)		4b. City, Town, o	r Location of Dea		4c. County of	<u> </u>
			Hospice of the			Linthi				Arundel
	Funeral Director		5. Social Security Number 218 03 2803 Usual Residence of Decedent	. Sex 7. Age (In) 1	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		29,1912	9. Birthplace (State or Foreign Country) North Dakota
	yland yland		10a. State 10b. County	10c	. City, Town or Lo	cation				10d. Inside City Limits
	e Maria	ctor	Maryland Anne	Arundel	Baltim	ore				1 ☐ Yes 2 🗓 No
	with th	Directo	10e. Street and Number 217 Seward Av	WODIIO.		10f, Zip Code	225	1	10g. Citizen of Wh	at Country?
	ns 23	Funerai	11, Marital Status	12, Was Decedent Ever i	in U.S. 13.			Specify Yes or No- rto Rican, etc.)		- American Indian,
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Ie marked other than "naturel", or items 23a or 28a-f show aumatic event, if a Medical Exa , if art mart be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		lf Yes, specify Cuba 1 ☐ Yes 2 🙀 No		rto Rican, etc.)		White, etc. White
Maryland 21215-0036	72 hc	Completed	15. Decedent's (Specify only highest		(Give	dent's Usual Occup	durina most of w	orking	16b. Kind of Busi	ness/Industry
121	within ene. than '	Jupi	Elementary/Secondary (0-12) 7 th	College (1-4or 5+)		<i>DO NOT use retired</i> Water Tu	,		City Go	vernments
2	illed Hygi other	Be Co	17. Father's Name (First, Middle, La	st)			18. Mother's Na	ame (First, Middle,		
lar	should be and Mental marked o umatic eve	To B	John	n Hockhalter			A1t	oina Lehr		
Jan	is 1 and 2 should of Health and Men item 27 le marke other traumatic		19a. Informant's Name/Relationship Robert Hockhalt					Rural Route Number	-	
	Health Health tem 27 other tr		20a, Method of Disposition		b. Place of Dispo	sition (Name of		Date Fra		Illinois 60423 ity or Town, State
altimore,	Pages nent of h ant: If it		1 XBurial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spe	□Removal from State		matory or other place 11 Cemete		11/2005	Baltimor	re, Maryland
a	permit. Pages Department of Important: If i any injury or o		21. Signature of Funeral Service Lic		1 - 22	2. Name and Addre	ss of Facility	Gonce Fun	eral Ser	vice, P.A.
<u> </u>	82 = 8		Jecome 7	nomerous						laryland 21225
T.	Physician		23a. Part1. Enter the disease, cock, or heart failure. List or Immediate Cause (Final disease or condition	omplications that caused the cause on each line. METAS 774				AN (E	_	Approximate Interval Between Onset and Death 2 ~ 3 MONTHS
	/Medical Examiner		resulting in death)	Due to (or as a con		•				
		ē	Sequentially list conditions, Tarry, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cor.	выфианта эт):					
	cuted nd ransit	Examiner	that mitiated events	c						
Ö,	oe execian ar	i Ex	resulting in death) Last	Due to (or as a con	nsequence of):					
8760,	icate be executed physician and s the burial-transit	dicai		d						
Box 6	eath certific attending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre					23d. Date	of delivery
o.	that the death ed by the atte detached for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 2□F 4□Pregnant at time 9□Unknown		Ectopic pregnancy Other (specify)			Monti	n Day Year
rds, P.	w requires that been signed be should be det	by	Part II. Other significant condition	s contributing to death but not	t resulting in the u	nderlying cause giv	en in Part I.			ute to the cause of death?
Records,	as s	Completed						24a. Was a autops perfori	sy prie	ere autopsy findings available or to completion of cause of ath? Yes 2 \[\] No
Vital		Be C	25. Was case referred to medical examiner?					eath (Check only or		
	Attending Physicien: The r death. ector: After this certificate his cy the funeral director, page	ion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time o Injury	f 28c. Injur Wor	4 U Nursing	Home 5 Reside	ence 6 Other ow injury occurred	
Division of	al or Attendate after death	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be Riggs of Injury	At home, farm, str pecify)			28f. Location (Si City or Town	treet and Number n, State)	or Rural Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best of my caminer: On the basis of examiner stated.	knowledge, deat mination and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	ce, and due to the courred at the time, d	ause(s) and manr late and place, and	er as stated. d due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	2-4		29c. Licens		2	9d. Date signed ((Month, Day, Year)
	91		· court pl	W ms.		425	408		7/6/	05
10	Y		CAPLIOS D. 216		(Item 23a) (Type, FE106	Print) 1406 S.C.	PAIN HE	uy, GLEN	BURNIE	MS 2106/
	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 0	32/Registrar's S	The state of the s	Wall of			,	

		1 - For State Registrar	State of Maryland	/ Depa <i>Cer</i>	irtment of H	lealth and Death	Mental Hy	giene Reg. No.	005	30471
Physicia	an	Decedent's Name (First, Middle, Last)	N S.	- i 1 :	01 04 50		2. Date of Do Month	eath Day	Year	3. Time of Death
/Medic Examin		HELE 4a. Facility Name (If not institution, give st			OLMES 4b. City, Town, or		SEPTEM h		2005 County of Death	7 /
Funeral Director		5. Social Security Number 6. Sex	ALTH 7. Age (In yrs. last	t birthday) Yrs.	GLEN If Under 1 Year Months Days	BURN If Under 24 Hrs Hours Min.		rth ay, Year)	9. Birthp Cour	RUNDEL place (State or Foreign ntry)
2 should be filed within 72 hours after death with the Maryland and Menial Hygiene. Is marked other than "natural, or items 23e or 28e-f show sumatic event, the Medical Examiting must be multified at	or	Usual Residence of Decedent 10a. State 10b. County MD BALTIMO	10c. City, T							1 Od. Inside City Limits 1 ☐ Yes 2 ☑ No
or 28a-	Director	10e. Street and Number	AE CO. FIAI	LEI	HÜRPE 101. Zip Code			10g. Citiz	en of What Cour	ntry?
death wi	Funerai D	14317 SPRIN 11. Marital Status	2. Was Decedent Ever in U.S.	13. <u>V</u>	Vas Decedent of H	ispanic Origin? (S	pecify Yes or No	o- 1	U S /	can Indian,
72 hours after dea "natural", or items	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes, specify Cuba	Specify:	to Mican, etc.)		Black, White, Specify: WH	etc.
hin 72 ho n. na "natur Medical	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		(Give i	ent's Usual Occupi kind of work done o OO NOT use retired	during most of wo	rking	16b. Kin	d of Business/In	dustry
filed wit Hygiene thar the		17. Father's Name (First, Middle, Last)	Sollogo (T. 101 ST)	A	COUNTA	NT, BOO				STORE
2 should be filed withir and Mental Hygiene. Ia marked othar then aumatic event, Itte Ma	To Be	CARL SPR				LOT	TIE	Bo	OWSHI	
ges 1 and 2 should be filed within 72 hours after death with the Maryla it of Health and Mental Hygiene. If item 27 Is marked other then "natural", or items 23s or 28s-f show or other traumatic event. The Medical Examinate must be multified at or other traumatic.		19a. Informant's Name/Relationship (Typ	N 4	4317	g Address (Street a			THOR	PE, MD	21227
Pa mer ant ury		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re ' 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	etery, crem IEW	created and the contract of th	DRY 9/	12/05	BA	ation - City or To	E MD.
permit. Departimport any inj		21. Signature of Funeral Service Licenses	amiroush.		Name and Address	ss of Facility	ONCE	FUN	ERAL S	ERVICE P.A. 21225
Physician		23a. Pan Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death. It is cause on each line.		er the mode of dyin	g, such as cardiae	or respiratory a	irrest,		Approximate Interval Between Onset and Death
/Medical Examiner bhysician and the burial-transit	dicai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequen	C L I					m	20404
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	ic. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 🗆	Ectopic pregnancy Other <i>(specify)</i>			23	3d. Date of delive Month	ery Day Year
w requires that been signed b should be deta	by	Part II. Other significant conditions cont	ributing to death but not resultin	ng in the un	derlying cause give	en in Part I.		obacco us		ne cause of death?
rsician: The law rec certificate has bee lirector, page 2 shou	Completed						24a. Was auto perfo 1 \(\text{Yes}			psy findings available inpletion of cause of
ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatient	3 □ DOA Othe	26. Place of Dea			☐Other (Specify	v)
ath. r: After thi	ation: T	27. Manner of Death 1 ANatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28	b. Time of Injury	28c. Injury Work	at	28d. Describe			,
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (City or To		Number or Rura	l Route Number,
e Hospi 24 hour a Funer letely fill	Medical	29a. Certifier (Check only one) Certifying Physical Exemination (Check only one)	cien: To the best of my knowle er: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the time estigation, in my op	ne, date and place pinion, death occu	, and due to the irred at the time,	cause(s) a date and p	ind manner as st place, and due to	ated. the cause(s)
To th within To th	Me	29b. Signature and title of certifie	ian-		29c. License				signed (Month,	
119		30. Name and address of person who com			Print)		Y .	-144)	1	12/2005 $2/090$
Sta	te	JOHN SHAVEN 31. Date filed (Month, Day, Year)	32. Registrar's Signature	CA	JONES MIS	הם רו נפנים	om,	411	THIC	un, no
Registra		050 9 0 2	nos Mesause	B. A						

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar		State	of Maryla	nd / Depa	artment of F rtificate of	lealth an <i>Death</i>	id Mental Hy	/gier le Reg. No.	005	30472
	Physicia	an	Decedent's Nan	me (First, Middle, L	ast)					2. Date of D Month	Day	Year	3. Time of Death
	/Medic	al		ll Chris				41. Ch. T.		Septer		11, 200	
	Examin	er		(If not institution, gi nner 100p			Road	4b. City, Town, o		Death		County of Deat altimor	
	Funeral		5. Social Security	Number 6.	Sex		s. last birthday)	If Under 1 Year	If Under 24		irth		hplace (State or Foreign
	Director		213-27-6	5441	1 M 2 □ F	20	Yrs.	Months Days	Hours	Min. (Month, D Dec. 25			vland
	pur *		Usual Residence			10c. C	City, Town or Lo	eation			,		10d. Inside City Limits
	daryli f •ho	ō	Maryland	Harfo	rd		Joppato						1 Yes 2 No
	28a-	rect	10e. Street and No	umber			LI	10f. Zip Code			10g. Citiz	zen of What Co	
	h with	al D	127 Stil	ll Meadow	Drive			2108	5		TT	SA	
	eme :	Funeral Director	11. Marital Status			cedent Ever in Forces?	U.S. 13.			? (Specify Yes or Note:)		4. Race - Ame Black, White	
9	n 72 hours after death with the Maryland "natural", or iteme 23a or 28a-f ehow calcal Executive count be notified at	by Fu	25	rried 2 Married 4 Divorced	1 ☐ Yes If Yes, G Year or	2 XNo Sive		1 ☐ Yes 2 ☒ No	Specify:			Specify: Bla	
3	tural stural	ed t	3 - **100*****	15. Decedent's I		Dates.	16a. Dece	dent's Usual Occup	ation		1	nd of Business/	
5	c * 3	Completed	(Spe	condary (0-12)		(1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of d)	f working			,
7	e filed within al Hygiene. I other then ' went, it e Ma	Con			2		Compu	iter Tec	hniciar			Comput	er
	be file d oth	Be		(First, Middle, Las						Name (First, Middle			
2	should Ind Meni	٢	Lionell	Emory Name/Relationship	Hill (Tupe Print)		19b Mailie	og Addrage /Stragt	Danne	or Rural Route Numi	fftee		
	and 2 sho Belth and n 27 is m			e C. John		other							yland 21085
ည်	- I 5 5		20a. Method of Oi		211		Place of Dispo	sition (Name of natory or other place	cel	Date	20c. Loc	cation - City or	Town, State
Ē	Pages nent of ant: If it ary or o		1 ZbBu fal 2 4 □ constion	☐ Cremation 3/ 5 ☐ Othe (Spec	Demoval from	Da		on Cemete		/15/2005	Darl	ington,	Maryland
Dali	permit. Pages Department of important: If it eny injury or o		2	The state of the	Say (hMs	22	. Name and Addre	ss of Facility	McComas l	Funer	al Home	P.A.
_	₹0.5 € d		1000		0//	WO.	11 13	317 Cokes	bury Ro	d., Abing	don, l	Marylan	
			shock, or he Immediate Cause	an failure. List onl					ig, such as cai	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condit resulting in death	ion		MIPLE		muss					
	Examiner				Due to	o (or as a conse	equence of):						
		ner	Sequentially list of cause. Enter Und Cause (Disease of	onditions,	b. — Cua ti	o (or as a nonse	equanoa of):						
	nd, transi	Examiner	Cause (Disease of that initiated even resulting in death)	(S	c								
8/60,	ificate be executed g physicien and as the burial-transit		resulting in death,	Last	Due to	o (or as a conse	equence of):						
ğ	physi s the t	edical			d								
×	din		IF FEMALE: 23b. Was decede	ent pregnant		utcome of preg					2:	3d. Date of deli	iverv
מ	0 0	Physician/M	in the past 1	2 months?	4□Preg	birth 2 □ Fe gnant at time of]Ectopic pregnanc _] Other (specify) _	<i>i</i>			Month	Day Year
j S	res that the de igned by the be detached	hys	9 Unknow		9□ Unk								
<u>,</u>	requires thet the een signed by th nould be detache	þ	Part II. Other sign	nificant conditions	contributing to	death but not re	esulting in the u	nderlying cause giv	en in Part I.				the cause of death?
cords		eted								_	Yes 242		obably 4 Unknown
မို	2 2 2	Completed							_	24a. Was		24b. Were au prior to death?	topsy findings available completion of cause of
<u>E</u>	ilcian: Th	ပို	25. Was case refe	erred to medical	_				20 Di	Yes	2 □ No	10 Yes	2 □ No
5	Physician: The this certificate har al director, page	To B	examiner?		Hospital:	Inpatient 2	☐ ER/Outpatien	t 3 DOA Oth	00	Death (Check only ng Home 5 ☐ Res		NOther (Spec	scene
	F E		27. Manner of Dea	ath 5 Pending	28a. Date (Mc	e of Injury onth, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe		occurred	your e Treas
<u> </u>	Attending r death. sctor: After by the fune	catle	2 Accident	investigate	on Q-1	Lor	01591		Yes 2∐No	DRIVEN	oreus		their ason
UNISION	or Att	Certification:	3 Suicide 4 Homicide	determine	A 289. Plac	ce of Injury - At ding, etc. (Spec	home, farm, str cify)	eet, factory, office		28f. Location City or To	(Street and wn, State)	Number or Ru	iral Route Number,
_	pitei ours e eral (29a. Certifier	1□ Cartifying F	hysician: To f	TODY		Occurred at the tir	no data and o	T695			robdunians w
	• Hos 24 h • Fun letely	edical	(Check only one)	2 Medical Ex	aminar: On the	basis of examir	nation and/or in	vestigation, in my o	pinion, death	occurred at the time	, date and p	place, and due	to the cause(s)
	To the Hospitel or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the to	Me	29b. Signature an	d title of certifier				29c. Licens	e number		29d. Date	signed (Month	n, Day, Year)
)	_		> WC	White !	he 16	lle	MM	OCME			Septe	ember 1	1. 2005
	7		30. Name and add	dress of person who			эт 23а) (Туре,	Print)			•		•
iį			31. Date filed (Mo	onth. Day, Year)		Figistrar's Sign	nature	111 Per	nn Stre	et, Balti	more,	, Maryla	and 21201
	Sta Registr		J. Date filed (MC	SFP 2 0	2005	Donas o	11 4	as well					

DHMH 17 Rev 1/2001

Registrar

2005

SEPTEMBER 13,

HECKLER

			1 - For State Registrar	State of Maryla		artment of H		Mental Hygi	ene 2005	30474
	Physici		1. Decedent's Name (First, Middle, La DELORES IR	LELAND				2. Date of Death Month	Day Yea	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, giv	re street and number)		4b. City, Town, or			4c. County of De	path
	Funeral		5. Social Security Number 6. S		TAL rs. last birthday)	LOLUMB: If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. 8	(State or Foreign Country)
	Director		218–26–6789 Usual Residence of Decedent	10 M 20 F 74	Yrs.	Months Days	riogis Will	07/17/1	931 M	aryland
	aryland show	7.	10a. State 10b. County	10c.	City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	the M	Director	Maryland Howard 10e. Street and Number		Elkr	idge 10f. Zip Code		10	g. Citizen of What	
	23a or	ai Di	5728 Elkridge Hei	ghts Road			21075		United S	•
39	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Heatth and Mental Hygiene. If item 27 is marked othar than "natural", or Itams 23a or 28a-f show or other traumatic event, the Medical Examinar must be rediffed at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ar Black, Wi Specify:	merican Indian, nite, etc. White
2-0	"natura	Completed by	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occupa	luring most of wo	orking 1	6b. Kind of Busines	s/Industry
2121	d within jiene. ir than	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		ir Stylis			Hai	r
Maryland 21215-0036	ild ba file lental Hyg ked otha ic event,	To Be C	17. Father's Name (First, Middle, Last William Stanley					me (First, Middle, M. ary Ann Sw		
Mary	12 shouh and Mand Mand Mand Mand Mand Mand Mand		19a. Informant's Name/Relationship (Susan M. Ireland	** *				ural Route Number,		
re, l	of Healt item 2		20a. Method of Disposition	205		position (Name of matory or other place			Le, Mary. Oc. Location - City	land 21093 or Town, State
Baltimore,	Pages tment of I tent: If it		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	(y)	Loudon	Park Ceme	tery 9/2			, Maryland
Ba	permit. Pages 1 and 2 : Department of Health ar Importent: if item 27 is any injury or other trau 9008.		21. Signature if Funeral Service Lice	-lind	- 1	2. Na <i>m</i> e and Addres 4107 Wilk		Hubbard Fu nue, Balti	neral Hon More, Mai	me, Inc. Cyland 21229
		S:	23a. Partl. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	1.0			c or respiratory arres	St,	Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a. DIABETIC Due to (or as a cons	equence of):	ACIDOS				
	Examiner	-6	Sequentially list conditions,	b. MYOCARDI		NFARCTI	N			
V	ocuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· HYPOTHYR	DIDIS	M				
8760,	cate be executed physician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a cons	equence of):					
Ó	rtificate ng phys	Medic	IF FEMALE:	d						
O. Box	law requiras that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burral-transit	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pred 1 Live birth 2 For 4 Pregnant at time of 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
ds, P	uiras that signed b d be deta	d by Pt	Part II. Other significent conditions of	contributing to death but not r	esulting in the u	nderlying cause give	on in Part I.			to the cause of death? Probably 4 🖫 Unknown
Records,	e taw require has been si ge 2 should b	Completed						24a. Was an autopsy	24b. Were	autopsy findings available o completion of cause of
	The ate h page							performe	ed? death' SINo 1 ☐ Ye	
Vital	rsicien: Th s certificate director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Anpatient 2	☐ ER/Qutpatier	nt 3□ DOA Othe		ath <i>(Check only one)</i> Ho <i>m</i> e 5□ Residen	ce 6 □Other (Sr	acifu)
Division of	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certification is the funeral director, completely filled in by the funeral director,	ation: T	27. Manner of Death 1 ⅓ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of	f 28c. Injury Work	at ? ′es 2 □ No	28d. Describe how		өспу)
Divis	el or Attenos after death	Certification:	3 Suicide 6 Could not be determined		t home, farm, str ocify)	eet, lactory, office		28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospitel within 24 hours a To the Funeral completely filled	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exer	nysicien: To the best of my k miner: On the basis of exami and manner stated.	nowledge, deatl ination and/or in	n occurred at the tim vestigation, in my op	e, date and place inion, death occu	e, and due to the cau urred at the time, date	ise(s) and manner e and place, and di	as stated. ue to the cause(s)
,	To the within To the comp	M	29b. Signature and title of certifier			29c. License	58580	1	1. Date signed (Mo.	
	10		30. Name and address of person who BAI KANU M.D.	completed cause of death (I	tem 23a) (Type,				1.0120	
	Sta Registr		31. Date liled (Month, Day, Year) SEP 2 0 200	3 Registrar's Sig			-11.0			
			V E.		,					

			For	State of Maryland	d / Department of I		ental Hygi		001 77
			For State Registrar 1. Decedent's Name (First, Middle, Last,		Certificate of		Re 2. Date of Death	g. N2005	30475
	Physici		CHARLE	JOHNSO	IN	,	Month G	Day Yeer 9 05	12.45 M
	/Medic Examin Funeral Director		5. Social Security Number 6. Sec	street and number)	center Birrton		8. Date of Birth (Month) Day;	4c. County of Deat Montgom (9. Birt Co	
	and *		Usual Residence of Decedent 10a. State . 10b. County	10c. City	/. Town or Location		- VI - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		10d. Inside City Limits
	the Maryit 28e-f sho	ector	MD Montgon	nem SILI	ler Spring		10	g. Citizen of What Co	1 X Yes 2 □ No
	h with	al DI	12001 old Cold	umbia PII	ice is	20904		WHITE	y.
036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28e-f show event, the Medical Evar, fractional terminal termination at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ဤYes 2 ☐ No If Yes, Give Year or Dates:	S. 13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Specian, Mexican, Puerto R Specify:	cify Yes or No- lican, etc.)	14. Race - Ame Black, Whit Specify:	
2-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad		16a. Decedent's Usual Occu (Give kind of work done	during most of working	9 1	6b. Kind of Business/	Industry
21215-0036	filed within Hygiene. Ither than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) Ø	'life. DO NOT use retire RESTAURANT MAN	•		FOOD SERVICE	ES.
nd	be filed tal Hygis d other event, I	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M		
Maryland	should be and Mental marked c	ဥ	David Clark Johnson 19a. Informant's Name/Relationship (Ty	rne Print)	19b. Mailing Address (Stree	Nova Ann		City or Town State	Zin Code)
	nd 2 s lith ar 27 is r trau		GLADYS MAE HICKMAN JOH		12001 OLD COLUM				
Baltimore,	e = 5		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 △ F		lace of Disposition (Name of emetery, crematory or other pla	Da	ate 2	0c. Location - City or	Town, State
Him	permit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licens		NCLIFF CEMETERY 22. Name and Address	9/23/		PRINGFIELD,	
Ba	permit. I Departm Importal any inju) Nan c	2 WMb.		SPRING ROAD,		L HOME, INC. MARYLAND 2070	
	Physician		23a. Part 1. Enter the disease, or complishock, or heart failure. List only of immediate Cause (Final disease or condition	ications that caused the death ne cause on each line.	n. Do not enter the mode of dy	ing, such as cardiac or	respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):		V		
1		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	andery hb	163:3			
	icate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o					
8760,	be exercian a	Ical Ex	resulting in death) cast	Due to (or as a consequ	dence of):				
9	tificate ig phys as the			d					
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3 Ectopic pregnance	y		23d. Date of del Month	very Day Year
	es that igned by be deta	by Pr	Part II. Other significant conditions con			ven in Part I.	23e. Did toba	acco use contribute to	
ord	v require been sig should t	eted	Chronic Ah	icel fibril	lahon		1 🗆 Yes	2 □ No 3 □ Pr	obably 4 @Onknown
Il Records,		Completed					24a. Was an autopsy perform	prior to d	topsy findings available completion of cause of
Vital	sicien: Th certificate irector, pag	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DOA	26. Place of Death	******) ice 6 ⊡Other (Spec	sit i
of	nding Phys th. :: After this e funeral di	1-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury Wo			v injury occurred	лу)
Division	al or Attendi s after death, il Director: A id in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, factory, office	28	8f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 12 Certifying Phy 2 Medicel Exemi	sicien: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death occurred at the t tion and/or investigation, in my	ime, date and place, ar opinion, death occurred	nd due to the cau d at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier		29c. Licen	se number 545t6		d. Date signed (Monti	n, Day, Year)
			30. Name and address of person who co	omoleted cause of death /item		-1200	Section 1	17-77-	
						en 230	There o	N MAZI	178
	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 0 20	32. Régistrar's Signa	ture Sparke	,			

			1- State of Maryland / Dep Registrer 27 per Dr., G847,09/20	artment of Health and N 0/05dhb rtificate of Death	Mental Hygi	ene 2005	30476
R.	Physic /Medi		1. Decedent's Name (First, Middle, Last) Patricia Johnson		2. Date of Death Month	Day Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number) 2305 James Street	4b. City, Town, or Location of Death Ealtimore Cit		4c. County of Death	
7	Funeral Director		5. Social Security Number 6. Sex 7. Age (<i>In yrs. last birthday</i> , 216−76−3184 1 □ M 2X□ F 42 Yrs.		8. Date of Birth Oct., 28,	O Diete	place (State or Foreign
	pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L.	ocation	1		10d. Inside City Limits
	ith the Marylar or 28e-f show	ector		imore			1 ∑Yes 2 □ No
	th with the 23s or 2	Funeral Director	10e. Street and Number 2305 James Street	10f. Zip Code 21230		g. Citizen of What Cour	ntry?
960	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene titem 27 is marked other then "neturel", or Items 23a or 28e-1 show other treumetic event, the Madcal Examination until be multilled.	by	1X Never Married 2 Married 1 ☐ Yes 2 XNo	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: W	
Maryland 21215-0036	d within 72 ho piene. r then "netu	Completed	(Specify only highest grade completed) (Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired) Ce Mover	ing 1	6b. Kind of Business/Ind Moving Co	
land ;	2 should be filed withir and Mental Hygiene. Is marked other then eumetic event, Ite M.	To Be C	17. Father's Name (First, Middle, Last) Albert R. Johnson		e (First, Middle, M. Kauffma	aiden Sumame)	
	t and 2 shou Health and M tem 27 Is mai other treumel		19a. Informant's Name/Relationship (Type, Print) Deborah Sue Brown, sister 19b. Maili 231	ng Address <i>(Street and Number or Run</i> 1 James Street Ba	al Route Number, altimore,		
Baltimore,	0 0			osition (Name of matory or other place) dge Memorial Park		Oc. Location - City or To	
Balti	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Licensee	Name and Address of Facility Ambrose Funeral Ho 2719 Hammonds Ferr	me of La	nsdowne	
M. C.	Pnysician /Medical Examiner	er	23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		or respiratory arres	st,	Approximate Interval Between Onset and Death 2 YEWS
¥ 109289	ificate be executed g physician and as the burial-transit	edical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				
.O. Box	death cert e attending od for use a	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ory Day Year
rds, P	ires tha signed d be de	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderfying cause green in Part I.	23e. Did toba	cco use contribute to th	
of Vital Record		Completed			24a. Was an autopsy performe	prior to con death?	osy findings available inpletion of cause of
f Vit	is dir	To Be	25. Was case referred to medical saxaminer? 1 Yes 2 No	26. Place of Death	n (Check only one) me esiden		·)
	ing After une	ertification:	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation 28b. Time of Injury (Month, Day Year) Injury		28d. Describe how		
Division	Hospitel or Attend 24 hours after death Funerel Director: , stely filled in by the f	Certific	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town, :	et and Number or Rural State)	Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death one) Certifying Physicien: To the best of my knowledge, death one) Certifying Physicien: To the best of my knowledge, death one) Certifying Physicien: To the best of my knowledge, death one)	n occurred at the time, date and place, a vestigation, in my opinion, death occurred	and due to the caused at the time, date	se(s) and manner as sta e and place, and due to	ated. the cause(s)
	To t To t com	Σ	29b. Signature and title of certifier Nhama	29c. License number MD 42 8 3 6		B. Date signed (Month, D	- days
	1		30. N me and address of person who completed cause of death (Item 23a) (Type,			0 30	
	Sta Registr		31. Date filed (Month, Day, Year) 2/30/05 SEP 2 0 2005	forly			

DHMH 17 Rev 1/2001

ORIGINAL

Renee Claire Jones Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item#23aPI.perME, G850, 12-30-05 TI
State of Maryland / Department of Health and Mental Hygiene
1- State Unpend Item 23a, 27, 28a-f per me C850, 12-14-05 tas
Registrar

1- Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Of Maryland / Department of Health and Mental Hygiene
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State Of Maryland / Department of Health and Mental Hygiene
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1- State Of Maryland / Department of Health and Mental Hygiene
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-06366 crn 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 18, 2005 **Physician** 12:52 A M nenee /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 2503 Linwood Road **Baltimore** Parkville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 9. Birthplace (State or Foreign Country) MARYLAUN 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 M 200 F Yrs 217-02-7200 Usual Residence of Decedent Director with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b County or 28a-f show other treumatic event, the Madical Examiner must be notified at 1 Yes 2 No BALTI MORE Be Completed by Funeral Director WD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2123 2503 238 inwood filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married white. Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secendary (0-12) College (1-4or 5+) DHIONIST ruc 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill iment of Health and Mental H tent: If item 27 is marked other 1 ourangeal 2 Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Topotouve 200. E 21085 mother MO 203 Contee 20b. Place of Disposition (Name of cemetery, crematory opother Nace) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 permit. Page Depertment of Importent: If any Injury or once. 9-20-05 rocest Frans Funeral Chapel 22. Name and oddress of Facility YORK RO. Timonium MD 21093. 21. Signature of Funeral Servi PEACEFUL ALTERNATIVES FUNERAL+CREMATION CENTER hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line.

No anatomic or toxicology cause of Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of shock, or heart failure. List No anatomic or toxicology cause of death Immediate Cause (Final disease or condition resulting in death) Cardiac Arrhythmia **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner sicien end burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ŏ Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 12 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 \(\subseteq \text{No.} \) death? 1 Yes After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) at scene Certification: To 28a. Date of Injury Fourid (Mapth, Day Year) 9-18-05 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred unk Found 12:42 1 Natural 5 Pending 1 ☐ Yes 2 No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Found in residence 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2503 Linwood Rd. 4 | Homicide Parkville, Md 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ÷ 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 18, 2005 O.C.M.E. brodere

Registrar

State

111 Penn Street, Baltimore, Maryland 21201

30. Name and address of person who completed cause of the h (Item 23a) (Type, Print)

2. Registrar's Signature

HE OPERE Mike

SEP 2 0 2005

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 1 - For State Registrar Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician Filomena Elizabeth Julio SEPTEMBER 15, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days 1 □ M 2 → F 218-26-5068 75 July 23, 1930 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, its Mudical Examinar must be notified at 1 Yes X No Director Baltimore Randallstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with Innent of Health and Mental Hygiene. 4510 Allen Road United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ሺ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be for Department of Health and Mental I important: if item 27 is marked ot eny injury or other traumatic even 2008. Frank Di Julio Mary Pullifrone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Anita Savino (Sister) 4510 Allen Road, Randallstown, Maryland 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Most Holy Redeemer Cem 09/19/05 Baltimore, Maryland 4 □Donetion 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors Kallner MOOJJ3 8728 Liberty Road, Randallstown, Maryland 21133 Pay1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ADULT RESPIRATORY DISTRESS SYNDROME /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sicion and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physicien Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Nnknown HODGKIN'S DISEASE 1 ☐ Yes 2 ☐ No Completed Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed' 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Atter 1 Natural 2 Accident 5 Pending Injury atter death. 1 ☐ Yes 2 ☐ No investigation completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 9-16-05 14 D 28244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OWZIA TAQI M.D. 7601 OSLER DRIVE TOWSON MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

			For State	State of Maryla			or nealth an		Reg. No.	30400
			Registrar 1. Decedent's Name (First, Middle, Last)		tmoare	0,000	2. Date of De	ath	3. Time of Death
	Physici		C 1:	E	John	. <		SEPTEM!	Day Yes	- 7.65 AM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	2011		own, or Location of D		4c. County of D	~
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	Funeral		Social Security Number 6. Se	x 7. Age (In yr.	s. last birthday)	If Under 1	Year If Under 24	Hrs. 8. Date of Bir Vin. (Month, Da	460	Birthplace (State or Foreign Country)
	Director		218 22 4164	JM 2☐¥F 94	Yrs.	WOTUIS	Days	Aug. 1	, 1911 \	irginia
	D		Usual Residence of Decedent 10a. State 10b. County	100 (City, Town or Lo	scation				10d. Inside City Limits
	anyla shov	'n			•					1 ☐ Yes 2 🛱 No
	Ne M	ect	Maryland Anne Ar	undel	Baltim	10f. Zip (Code		10g. Citizen of What	Country?
	with t	급	613 Hammonds L	ane		10i. 2ip 0	21225		U.S.	Country:
	filed within 72 hours after death with the Maryland Hygione. ther then 'neturel', or Items 23a or 28e-f show ent, it s Madical Esta of ver cost be notified at	by Funeral Director	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decede		? (Specify Yes or No	- 14. Race - A	merican Indian,
10	r Iten	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🐼 No			ent of Hispanic Origin fy Cuban, Mexican, P	uerto Rican, etc.)		
036	el', o	ρ	3 Nidowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	No Specify:		Specify: W	nite
21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Dece	dent's Usual	Occupation done during most of retired)	workina	16b. Kind of Busine	ss/Industry
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Maryland	o d a	Be		am Adcock				ry Branha		
Ž	should Ind Meni	ပ္	19a. Informant's Name/Relationship (T)		19h Maili	na Address /			er, City or Town, State	e Zin Code)
Ma	d 2 s th an treur		Rosella Aro / Day			•	d Street		re, Maryla	
e,	1 and Health Iem 27 other tr		20a. Method of Disposition		Place of Dispo			Date	20c. Location - City	
no	Pages nent of int: If it		1 🔀 Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)	removal mom State			. Park 9/	21/2005	Glen Burn	ie, Maryland
Baltimore,	ortan		21. Signature of Funeral Service Licens						neral Serv	•
Ba	permit. Departr Importa any inji		Klmm m2	ministelle	1/1 4	001 Ri	itchie Hig	hway Bali	cimore, Ma	ryland 21225
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	certifi ding		IF FEMALE:	23c. If yes, outcome of preg	nancy				23d. Date of	delivery
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P.O.	that the death certif ed by the attending detached for use a:	Physician/M	9 Unknown	9□ Unknown						
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ital	en: rtifica	ø	25. Was case referred to medical				26. Place of	Death (Check only of		
of Vital	Physicien: r this certific ral director,	To B	examiner? 1 Yes 2 140	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatier	t 3□ DOA	Other: 4 Nursin	ng Home 5 Resi	dence 6 Other (S	pecify)
0 U	ng Pl		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	28	c. Injury at Work?	28d. Describe I	now injury occurred	
Sio	Attending r death. ector: After by the fune	cati	2 Accident investigation			М	1 ☐ Yes 2 ☐ No			
Division	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		eet, factory,	office	28f. Location (Street and Number or vn, State)	Rural Route Number,
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	To the Hospitel or Attending Physicien: The lav within 24 burus after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kiner: On the basis of examinand manner stated.	nation and/or in	vestigation, i	n my opinion, death o	occurred at the time,	date and place, and c	as stated. due to the cause(s)
	o the o the omple	Med	29b. Signature and title of certifier	- January States		29c.	License number		29d. Date signed (Mo	onth, Day, Year)
	- s + ŏ) (11.1.	0-			AZOTET	-	Sentanten	10 2005
j.	\sim		30. Name and address of person who c	ompleted cause of death (It	em 23a) (Type,	Print) _a	· / / / / / /		Johnson	, , ;
1				MO.901 Ec		+ An	enn, Ba	thing.	ms 21.	230
	Sta	te	31. Date filed (Month, Day, Year)	32. Sigistrar's Sig		. 100	4			

			5	State of Marylan					-	_	
			1 - For Stata Registrar		Cei	rtificate	of Death			. No. UUS	30481
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2 -	JACO	hs			Date of Death Month	Day Year	
	/Medic Examin		4a. Facility Name (If not institution, give stre		37100		Town, or Location of		Eptember	4c. County of De	>2
h		Ĭ.	4131 DORIS AUEN				altimore	GALLES I		N/A	
	Funeral Director		5. Social Security Number 6. Sex 125 6. Sex	7. Age (In yrs. 85	last birthday) Yrs.	If Under Months	1 Year If Under Days Hours	Min.	Date of Birth (Month, Day, Yug. 28,	^(ear) 1920 Ma	irthplace (State or Foreign Sountry) aryland
	and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d, Inside City Limits
	Maryl B-f sho	tor	Maryland N/A	Ва	ltimor	e					1 X Yes 2 □ No
	J within 72 hours after death with the Maryland jiene. 'then' natural', or Items 23e or 28e-f show the Medical Ezahii or must be rollified at	Director	10e. Street and Number 4131 Doris Ave	nue		10f. Zip	Code 21225		10g	U.S.	Country?
	death	nera	11. Marital Status 12.	Was Decedent Ever in U. Armed Forces?	S. 13.	Was Deced	ent of Hispanic Ori	igin? (Specif	y Yes or No-	14. Race - Am Black, Wh	
50	hours after tural', or Ite	by Funerai	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 EYes 2 No If Yes, Give WW I Year or Dates: WW I		1□Yes 2			,,	Specify: W	
2	72 hou nature	eted	15. Decedent's Educat (Specify only highest grade c	ion	16a Decer	dent's Usua kind of wor	l Occupation k done during mos e retired)	t of working	16	6b. Kind of Busines	s/Industry
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ylandz	be filed tal Hygir d other event, t	Be	17. Father's Name (First, Middle, Last)	Jacobs, Sr.	'			er's Name <i>(F</i> Grace	Porry	iden Sumame)	
Ε.		우	19a. Informant's Name/Relationship (Type,			ng Address				City or Town, State,	Zip Code)
, Ma	s 1 and 2 should f Health and Mer fem 27 is marke other treumetic		Ruby Jackson / sis	ter	4131	Dori	s Avenue	Ва	ltimore	, Marylan	d 21225
ore,	eg = 5		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Rem		lace of Dispo			Date 9/20/2		c. Location - City o	r Town, State Maryland
Baltimor	그 문원을 .		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licensee	/ Ce	dar Hi					ral Servi	•
ñ	Depa Impo any ir once.		Jarone Bron	moush	~						yland 21225
			23a. Part 1. Enter the disease or complica shock, or heart failura List only one Immediate Cause (Final	tions that caused the death cause on each line.	n. Do not ent	er the mode	of dying, such as	cardiac or re	spiratory arrest	t,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a	Due to (or as a conseq	uence of): /	100	thy				10 years
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X Q Q	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregna	death 3	Ectopic pre				23d. Date of de Month	elivery Day Year
j.	t the de by the a	hysic	1 Yes 2 No 9 Unknown	4☐Pregnant at time of d 9☐Unknown	ealli 5	Other (spe	эспу)				
Б	w requires that the death certifica s been signed by the attending ph should be detached for use as th	by	Part II. Other significant conditions contri	buting to death but not res	ulting in the u	nderlying ca	use given in Part I.		23e. Did tobac		robably 4 Unknown
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UIVISION	Attending or death. ector: After by the funer	licati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At he	ome, farm, str	M reet, factory	1 Yes 2 1		Location (Stree	at and Number or F	Tural Route Number,
2	tel or A	Certification:	4 Homicide	building, etc. (Specify	v)				City or Town, S	State)	
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical		ian: To the best of my kno : On the basis of examina and manner stated.							
	To the within To the comple	Me	29b. Signature and title of certifier	1	20		License number		29d.	. Date signed (Mon	
	140		30. Name and address of person who comp	oleted cause of death (Item	1 23a) (Type.	Print)	0 177	40		09/19/	05
	0 7		L. SEENIVASAN, N	10, #2160	RUEHY	v Bio	9001	S. HA	HVOVEA	RST, BAL	-To, 21225
10	Sta Registr		31. Date filed (Month, Day, Year)	32. Hegistrans Signa	iure	Sporte					
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			1 - For State Registrar	State of I	Maryland /	-	artment			and M		giene	105	301.82
			Decedent's Name (First, Middle,	Last)							2. Date of Dea	ath		3. Time of Death
Е	Physici /Medic		ELMER JAMES JO	ONES							SEPTEMB	ER 15	, 2005	11:20 A ^M
	Examin		4a. Facility Name (If not institution,		er)				Location o			1	ounty of Death	
			6730 ELDORADO RO		Age (In yrs. last	hirthday)	Fede		sburg		8 Date of Birt		Caroline	
	Funeral Director		220-10-1748	1 XM 2 □ F	88	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da) 1-19-1	917	Coun	lace (State or Foreign try)
	o o		Usual Residence of Decedent											
-	arylar show	_	10a. State 10b. County		10c. City, To								11	0d. Inside City Limits 1 ☐ Yes 2√ No
	the M	ecto	MD Caroli	ne	Fede	ralsi	ourg 10f. Zip	Code				10a Citizer	n of What Coun	
3	With With	Ö	6730 Eldorado R	đ				2163:	2			U.S.		
	ms 2:	Funeral Director	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S.	13.				gin? (Spe	ecify Yes or No- Rican, etc.)		Race - Americ	
و	or the	Ē	1 ☐ Never Married 2 🔀 Marrie	1 XYes 2	□No Army	_	1 Yes 2		Specify:	, FDerio	nican, etc.)		Black, White, o	
	filed within 72 hours after death with the Maryland Hyglene. Hyglene. Insture!; or Items 23e or 28e-f show ant, the Medical Evantine must be notified at	d by	3 Widowed 4 Divorced	Year or Date		11					-			
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_	m - 0 5	BeC	17. Father's Name (First, Middle, La	est)							(First, Middle,	Maiden Su	mame)	
y Z	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene and Mental Hygiene is marked other then "natural", or items 23e or 28e-f show eumatic event, the Medical Examinat must be notified at	P	William Henry								Moore			
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic events.		19a. Informant's Name/Relationship Mrs. Genevia T.		1						alsburg			Code)
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ē,	Pages ent of nt: If i		1 🕅 Burial 2 □ Cremation 3 4 □ Qonation 5 □ Other (Spe		Meado				1	-19-	2005	E1kri	dge, MI)
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n			1 Mini Bell	les 1	101344	1	Seco	nd Av	ve SW	; G1	en Burn	ie, M	D 21061	
			23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that cause on each	sed the death. 'Dan line.	Oo not ent	er the mode	e of dying	, such as	cardiac c	r respiratory ar	rest,		Approximate Interval Between Onset and Death
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, S	s the	by F	Part II. Other significant condition	s contributing to deat	h but not resultin	g in the u	nderlying ca	ause give	n in Part I.					e cause of death?
cords,	v require been sig should b	ted										es 2□N	lo 3 ☐ Proba	ably 4 Unknown
- EC	the law cate has b page 2 sl	Completed									24a. Was autop	sy	4b. Were autor prior to con death?	osy findings available npletion of cause of
-	(0	e Co	25. Was case referred to medical	1					00 Bl	of Doodb	1 Tes	2 No		2□ No
Vital	rnysician: this certific ral director,	OB	examiner?	Hospital:	atient 2□ER/	Outpatien	t 3 🗆 DO	A Othe	_	rsing Hor	n <i>(Check only ol</i> ne 5 ★ Resid		Other (Specify	()
	ig Physiter this neral di	T: U	27. Manner of Death	28a. Date of I		b. Time of		Bc. Injury Work			28d. Describe h			
SIOL	death. ctor: After y the funer	atic	1 Accident 5 Pending investiga	tion		,,	М		'es 2 □ N					
DIVISION	or Attending after death. Director: After in by the fune	ertification;	3 Suicide 6 Could no 4 Homicide determin	ed 288. Place of	Injury - At home, etc. (Specify)	, farm, str	eet, factory,	, office		1	28f. Location (S City or Tow		umber or Rurai	Route Number,
_	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	0	29a, Certifier 1 Cartifying	Physician: To the be	st of my knowled	dae. death	occurred a	at the time	e. date and	d place, a	and due to the o	ause(s) an	d manner as st	ated
	lo the Hospitel within 24 hours a To the Funerel to completely filled	edical	(Check only 2 Madical En	aminar: On the basis	s of examination	and/or inv	estigation,	in my op	inion, deat	th occurre	ed at the time, o	date and pla	ace, and due to	the cause(s)
	ro the within 2 To the complet	ž	29b. Signature and title of certifier				29c.	License	number		2	29d. Date s	igned (Month, L	Day, Year)
				/	- w	10	7	000	053	255	>	9	15/0	>5
	1		30. Name and address of person w	no completed cause of	of death (Item 23)	a) (Type,	Print)		2	1.0	a mr	201	655	
	Sta	te	31. Date filed (Month, Day, Year)		istrar's Signature	- NW	Man And	4 6	, , ,				(6)	
	Registr	-	SEP 2 0 2	005 /	in the	for	de							

			For State Registrar	State of Maryl		tment of Healt		tal Hygie	ZIIII	30484
	Physici	an	Decedent's Name (First, Middle, Last)		Kohn	0	2. [Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s	ford Kd.	Apt alo yrs. last birthday)	4b. City, Town, or Locat ALT y If Under 1 Year If Ur Months Days Hou	MORE	Date of Birth		h OPE hplace (State or Foreign
	Director		218-12-2103 1L Usual Residence of Decedent 10a. State 10b. County	M 20 F	. City, Town or Loca			11-2-0	6 mA	2 VLAND 10d. Inside City Limits
	the Maryla 28a-f aho	rector	MD BALTIN 10e. Street and Number	NORE	B1	LTI MORI	E	10g.	Citizen of What Co	1 ☐ Yes 2 No
	72 hours after death with the Maryland natural', or items 23s or 28s-f ahow iteal Examinar must be motified at	Funeral Director	8800 old Harfa	Rd. Ad 12. Was Decedent Ever Armed Forces? 1 yes 2 kino		as Decedent of Hispanic Yes, specify Cuban, Mer		Yes or No- n, etc.)	USA 14. Race - Ame Black, Whit	
5-0036	72 hours af 'natural', or dical Exam	þ	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade	If Yes, Give Year or Dates:	16a. Decede	int's Usual Occupation	most of working	16	Specify: LO	hite.
12121	filed within Hygiene.	Completed	Elementary/Secondary (0-12) / 2 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	1	ondruse retired) emaker 18. M	Nother's Name (Fi	rst. Middle. Mai	at home	Q.,
Maryland	should be fand Mental but marked of	To Be	Herman Li	ebno	19h Mailing	Address (Street and No	Berth	a Fe	lhaus	Zip Code)
	es 1 end 2 of Health a of Item 27 to or other tra		Barry Kuhn 20a. Method of Disposition 1 Method of Disposition 3 GR	و	Db. Place of Disposicemetery, crem	ocster Ct	- Phoe	enix n	1D 211	3 / Town, State
Baltimore,	permit. Pag Department Important: any injury o		4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service/Licensy	aviolar	EV#	Name and Address of F	ALCHAR	EL 88	SALTIMO. FIMD Z RHARFO	ed RD.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or confol shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	fations that caused the cause on each line. Due to (or as a cor	MATIC	CANC/		OF V	LLUA	Approximate Interval Between Onset and Death
8760, 🏂 📑	sate be executed by sician end the burial-transit	licai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor						
P.O. Box 6	death certific e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 yponths? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 16	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
	w requires that the been signed by the should be detache	by	Part II. Other significant conditions con	ntributing to death but no	t resulting in the und	derlying cause given in F	Part I.	23e. Did tobac		o the cause of death?
al Records,	The law ate has b page 2 sh	Completed	-					24a. Was an autopsy performe	d2 death?	utopsy findings available completion of cause of 2 No
Vita	ysician: Th is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	2 ☐ ER/Outpatient	0	Place of Death (Ci □ Nursing Home		e 6 Other (Spe	city)
Division of Vital	Jing Ph J. After th funeral	Certification: T	27 Manner of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Yea 28e. Place of Injury -		28c. Injury at Work? M 1 ☐ Yes	28d. 2 🗆 No	Describe how		
Ο̈́	its after ral Dire		4 Hornidae	building, etc. (S				City or Town, S		
	To the Hospitel or Attending thin 24 hours after death To the Funeral Director: completely filled in by the	edical		sician: To the best of my ner: On the basis of exa and manner stated.						
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	1. L	M.D.	29c. License num			Date signed (Mont	h, Day, Year)
	15		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type, F	DOO18	MAN		1/14/	
(8)	St. Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	M. D	100			
Store	negisi	reil	SEP 2 0 200	7 Pagues	15 1500					

			For State Registrar	State of Maryland	Department of Health and Note of Certificate of Death	Mental Hygie		30485
	Dhysisi		1. Decedent's Name (First, Middle, Las	1 4		2, Date of Death Month	Day Year	3. Time of Death
4	Physici /Media		Thelma	Kane	and the state of Death	Sept. 1	17 2005	7:50PM
	Examir	er	4a. Facility Name (If not institution, give	. 1 - 1	4b. City, Town or Location of Death		4c. County of Death	
	Funeral		5. Social Security Number 6. S	eriatric (ont	birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign
	Director		214-20-0200	□м 20 (F 79	Yrs. Months Days Hours Min.	5-11-20	o. MA	RYLAND
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location	-		10d. Inside City Limits
	rs after death with the Marylan ", or Items 23e or 28a-f show Kaminer must be notified at	ξ	MD BALTIN	MORE	BALTIMORE			1 Yes 2 No
	h the	Funeral Director	10e. Street and Number	4 0 1	10f. Zip Code	10g.	Citizen of What Cou	intry?
	23e c	raiD	12918 Eastern		21220		USA	
	er dea Items	nue	11. Marital Status 1 ☐ Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White	
936	urs aft	þ	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 MNo If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: W	rite.
215-0036	ba filed within 72 hours after death with the Maryland ital Hygiene. d other than "naturel", or ttems 23e or 28e-f show event, the Medical Examinar must be notified at	Completed	15. Decedent's Ed (Specify only highest gra		6a. Decedent's Usual Occupation (Give kind of work done during most of work	king 16b	o. Kind of Business/Ir	ndustry
121	within ne.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		D.W hon	
d 21	ould ba filed with Mental Hygiene arked other that atic event, the	ပိ	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maid	den Sumame)	Q 1
an	lid ba lental rked c	To Be	Richard Lee	CRISE	Ruth	Robecci	a GRE	Y
Maryland	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship (Гуре, Print)	19b. Mailing Address (Street and Number or Ru	~ /2		
	permit. Pagas 1 and 2 should ba filed within 72 ho Department of Heath and Mental Hygiene. Importent: If item 27 is marked other than "natur any injury or other traumatic event, the Mcdical once.		Lawrence A. K	ine-husband	12918 Eastern Ave. 2	Date , DAL	DMORE	MD 2 H2C Town, State
Baltimore,	agas 1 nt of H : If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Hellioval Itolii State	e of Disposition (Name of etery, crematory or Otherpolace)			
Itin	permit. Pag Department Importent: I any injury o		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer 		22. Name and Address of Facility 232	26-05 F	Tingain	N.M.D 21092
Ba	permit. Depart Import any inj		Kin beel ul	1. Zashotal	1 - 1		-	MATION CIR.
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. I	Do not enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Pnysician	0.3	Immediate Cause (Final disease or condition	a Phenno				Onset and Death
	/Medical Examiner		resulting in death)	Du- to (or as a consequen	ce of):			
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequen	ce of):			
126	cutad	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c				
8760,0	cate ba exacutad bhysician and the burial-transit		resulting in death) Last	Due to (or as a consequen	ice of):			
	icate t physic s the b	Physician/Medical		d				
Box 6	w requires that the death certific been signed by the attending p should be detached for usa as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of deliv	/ery
W	death	sicia	in the past 12 months?	1 Live birth 2 Fetal de 4 Pregnant at time of deati 9 Unknown			Month	Day Year
P.O.	at the d by the	Phy	9 Unknowh		ng in the underlying cause given in Part I.	23e Did tohac	co use contribute to	the cause of death?
	signe d be d	b	Chronic Obtra	ctive pulmonary	disease Coronary		2 □ No 3 □ Pro	
of Vital Records,	w requ	Completed	autom diene C	1 +0	ni ni di di	24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
Re	ha lav e has age 2	dmo	5. 0.	surestive hears to	•	n autopsy performed 1 ☐ Yes 2 🔏	1? death?	
ital	Physician: The this certificate al director, pag	O	25. Was case referred to medical	ne Ular, anew		th (Check only one)	10 100	
> _	hysic his ce	To B	examiner? 1 Yes 2 No			lome 5 Residence		ify)
o uo	ding P h, Aftar t funera	lon:	27. Manner of Death 1 XNatural 5 ☐ Pending	(Month, Day Year)	lb. Time of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how i	njury occurred	
Division	death death ctor: y the t	ficat	2 Accident investigatio 3 Suicide 6 Could not b	e 28e. Place of Injury - At home		28f. Location (Stree	t and Number or Rui	ral Route Number,
Οį	al or A s after Il Dire	Certification:	4 Homicide	building, etc. (Specify)		City or Town, S	tate)	
	To the Hospital or Attending Physician: Tha law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for usa as:	Medical (29a. Certifier Check only one) Certifying Pl	sysicien: To the best of my knowle niner: On the basis of examination and manner stated.	edge, death occurred at the time, date and place a and/or investigation, in my opinion, death occu	, and due to the caus irred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	242	29c. License number	29d.	Date signed (Month,	, Day, Year)
			A. Mazin	, MD	D0060170	9	118/05	
	7,9		30. Name and address of person who A Ghazinou		3a) (Type, Print)	-	1	
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	θ			
	Regist		SEP 2 0 200	5 Sterner St.	poorles			

State of Maryland / Department of Health and Mental Hygien 2005 30486 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) r 17,2005 Month **Physician** Kassakatis September 9:43 A^{M} John /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 1818 Maxwell Avenue Dundalk Baltimore 8. Date of Birth (Month, Oay, Year) July 5, 1932 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days τ**Σ**Μ 2□ F Hours Months 73 Yrs. MD. Director 219-28-9421 Usual Residence of Deceden with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28e-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Dundalk Director Baltimore Md 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ 21222 USA Items 23a 1818 Maxwell Avenue death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 72 hours after 1 Yes 2 No If Yes, Give 1 Never Married Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2\OXNo Specify: Specify: þ White 3 Widowed 4 Divorced Year or Dates netural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Crown Cork & Seal Millwright 12 years other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 12 should be finance of and Mental F Ida Lancaster John A. Kassakatis Sr. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Importent; If item 27 Is n eny Injury or other traum 1818 Maxwell Avenue, Dundalk, MD. 21222 wife Mary Kassakatis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Bayview Crematory 22, 2005 4 ☐ Donation 5 ☐ Other (Specify) Baltimore City, MD. Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death KESPIRATORY FAILUKE Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** GRAVIS ayrs astuenia Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for all a consequence of Examiner Due to (or as a con equence of): certificate be executed use as the burial-transit ARCINOMA 6 mo attending physician Box 68760 Physician/Medical d IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown ģ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/ 2 🗆 No 2 No 1 Tes 1 Yes director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Hospital: 1 ☐ Yes 2 ▼No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Y esidence 6 Other (Specify, 2 this funeral 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospitel or Attending P 24 hours after death. e Funerel Director: After t Certification: 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide To the Hospitel within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 16705 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 0516 TIMOIL 22 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Consec. Registrar SEP 2 0 2005

				For State Registrar	of Maryland / De	partment of Health an		ier 2 e 0 0 5	30487
		Physici		1. Decedent's Name (First, Middle, Last)	(1)		2. Date of Death Month		3. Time of Death
		/Medic Examir		4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of D		4c. County of Death	
				Franklin Square Ho	spital Center	Rosedale		Baltimo	re
	4.8	Funeral		5. Social Security Number 6. Sex,	7. Age (In yrs. last birthd	ay) If Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Date of Birth (Month, Day,	Year) 9. Birthi	olace (State or Foreign
		Director		Usual Residence of Decedent	F 85 Yrs		August 2	4,1920 MC	ikyland
		land ow		10a. State 10b. County	10c. City, Town or	r Location			10d. Inside City Limits
		ours after death with the Maryland rai', or items 23a or 28a-1 ahow Exarilmer and be notified at	tor	MD Battimore	Bath	more			1 □ Yes 25 No
		r 288	Director	10e. Street and Number	<u> </u>	10f. Zip Code	10	g. Citizen of What Cou	ntry?
		th with	aiΩ	2812 Erie Avenu	2	21234		USA	
		dea	Funerai	11. Marital Status 12. Was	Decedent Ever in U.S. 1 1 Forces?	3. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Americ Black, White,	
	98	or it	Y.	1 Never Married 2 Marned 1 1	es 27 No Give	1 ☐ Yes 2 No Specify:	, ,	Specify:	110
	5-0036	72 hours after death w "natural", or items 23a	d by	3 Wildowed 4 Divolced Year	or Dates.	ecedent's Usual Occupation	1	1.0	nne
	15-		Completed	15. Decedent's Education (Specify only highest grade comple	ed) (G	ive kind of work done during most of e. DO NOT use retired)	working	l6b. Kind of Business/In	dustry
20	2121	within iene. r than "	mo	Elementary/Secondary (0-12) Colle	ge (1-4or 5+)	echanic	(Fas + Elec	tric Compan
الح	p	filed Hyg other	BeC	17. Father's Name (First, Middle, Last)			Name (First, Middle, N		
0	<u>lar</u>	Aenta Aenta rked tic ev	ToB	Harry Arnold Li	ne	Edn	a Ruth	Spesso	rd
0	Maryland	should be filed within and Mental Hygiene. Is marked other than aumatic event, Ite M.		19a. Informant's Name/Relationship (Type, Print,	19b. M	ailing Address (Street and Number of	r Rural Route Number,	City or Town, State, Zip	
9	Σ	s 1 and 2 of Health item 27 other tre		build Conrad Line		2 Cedarlea Drive			20778
.5	ore	of Heritary		20a. Method of Disposition 1 Substitute 2 □ Cremation 3 □ Removal f	om State cemetery, o	sposition (Name of crematory or other place)	,	20c. Location - City or To	own, State
V	altimor	Pag Iment tant: jury o		4 Donation 5 Other (Specify)	tackur	and Cemetery So	pt. 20 2005	Baltimon	e MD
	Sal	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any rigury or other traumatic event, ITEM ODE.		21. Signature of Funeral Service Licensee	and the	22. Name and Address of Facility 5		,	
		40.240		23a. Part! Enter the disease, of complications shock, or heart failure. Light only one cause	we not the deline of			-, mory land	Approximate
				Immediate Cause / Final		1) • /	diac or respiratory arre	31.	Interval Between Onset and Death
		Physician /Medical		disease or condition resulting in death)) espiratory to (or as a consequence of).	y tailure			
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	39 1	certificate Iding phys	Med	IF FEMALE:					
	Box 6	ath ce ttendi or use	lan/	23b. Was decedent pregnant		3 Ectopic pregnancy		23d. Date of deliver	ery Day Year
	0.	the a	sici	1 Vac 2 No	regnant at time of death nknown	5 Other (specify)			34,
	P.O.	hat that ad by detac		Part II. Other significant conditions contributing	to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobi	acco use contribute to the	he cause of death?
	Division of Vital Records,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	d by		•	, , , , , , , , , , , , , , , , , , , ,	1 ☐ Yes	s 2 1 No 3 Prob	oably 4 Unknown
	Sor	v requ been shoul	Completed				24a. Was an	24h Were auto	new findings available
	Re	2 8	Ę.				 autopsy perform 	ed?death?	psy findings available mpletion of cause of
	a	ificate or, pa		25. Was case referred to medical		26 Place of	1 ☐ Yes 2 Death (Check only one	1 Yes	2∐ No
	>	Physician: r this certific ral director,	To Be	examiner? 1 Yes 2 No Hospital:	☐Impatient 2☐ER/Outpa	Othor		nce 6 Other (Specif	(v)
	0	ding Phys h. After this funeral di		27. Manner of Death 28a. D	ate of Injury 28b. Time	e of 28c. Injury at	28d. Describe how		,,,
	ior	ath. or: Aff	atio	2 Accident investigation	mornin, Day Today	M 1 Yes 2 No			
	i≥i	r Atte	Certification:	3 Suicide 6 Could not be determined 28e. F	lace of Injury - At home, farm, uilding, etc. (Specily)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
	0	oltai o urs af rrai D							
		To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medicai	(Check only 2 Medical Examiner: On t	the best of my knowledge, de le basis of examination and/or nanner stated.	eath occurred at the time, date and p r investigation, in my opinion, death o	lace, and due to the car occurred at the time, da	use(s) and manner as si te and place, and due to	tated. o the cause(s)
		To th withir To th comp	M	29b. Signature and title of certifier		29c. License number	4 4	d. Date signed (Month,	Day, Year)
		/		Pondw Dr	NJ MD	D617	6 /	9/16/09	5
	-	h		30. Name and address of person who completed	cause of death (Item 23a) (Typ	con Klin Squar	> /) / (.	. 4.1
		J			Sad 9000 FT	anklin Squar	e Drive To	Da House,	NIC 21237
	18 18 18 18 18 18 18 18 18 18 18 18 18 1	Sta Registi		SFP 2 0 2005	2. Registrar's Signature	de			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra 30488 Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** SEPTEMBER 14, 2005 /Medical 4a. Facility Name (If not institution, give street and number, Examiner HOPKINS Johns HOSPITAL 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Days Hours Min. Yrs. Director Nov. Maryland 217-11-6423 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene.
nent of Heatth and Mental Hygiene.
nent of Heatth and Mental Hygiene.
nent 71 is marked other than "natural", or items 23e or 28e-f ehow that it is marked to be a confirmed any or other traumatic event, the Marked Example and 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1701 Manning Road 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ð 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 N/A Sales Associate Pet Store 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Sharon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert E. Lawton (Husband) 1701 Vanning Road Glen Burnie Varyland 21061 of Disposition (Name of Date Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State permit, Page Depictment of Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Elkridge Maryland Meadowridge Mem. Pk. 9/20/05 21. Signature of Fugieral Service Licenses Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 lo lline Approximate Interval Between Onset and Death 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. OBSTRUCTIVE HYDROCEPHAIUS Immediate Cause (Final Physician 2 DAYS disease or condition resulting in death) /Medical Examiner ChiARI MALFORMATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the as attending IF FEMALE: BSI 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ★ Fetal death
4 ★ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent prechant 3 Ectopic pregnancy jo Month Day Vear in the past 12 months? 5 ☐ Other (specify) Yes 2 □ No been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 certificate Yes 2 \ No or Attending Physiclen: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To funeral 27. Manner of Death 1. Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death, To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of centifier MD RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET, BALTIMORE, MD 21287 MATTHEW KOENIG, GOON, WOIFE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra DHMH 17 Rev 1/2001

ORIGINAL

		•	State of Maryland / Dep. State of Maryland / Dep. Registrar	artment of Health and N		ne . 2005	301.89
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Phys /Me	sicia edica		Genevieve O. Lechowicz	-	September	[™] 13, 2005	
Exa	mine	r	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
Fune	ral		5 Bideford Court 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Ye	Baltimore 9. Birth	e County pplace (State or Foreign untry)
Direct			107-01-2237 1□M 2∰F 89 Yrs.	Months Days Hours Min.	Month, Day, Ye December	15.15 Utic	ca, New York
and *	251		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Le	ocation			10d. Inside City Limits
Maryian f show		٥	Maryland Baltimore County Baltimo				1 ☐ Yes XXNo
h the		e l	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Cou	untry?
th with		Funeral Director	5 Bideford Court	21234		nited Sta	tes
er des Items		nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
urs aft		2	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify:	White
at y rail to Z Z 200000 should be filed within 72 hours after death with the Maryland nd Mental Hyglene. r marked other than "natural", or items 23a or 28a-f show unalic event, I a Medical Evential te multiplied at		Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation	ina 168	b. Kind of Business/l	ndustry
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Tally Iallo 6 16 16 within and Mental Hygiene. Is marked other than raumatic event.				ing Address (Street and Number or Rui	al Route Number, C	ity or Town, State, Zi	ip Code)
1 and 1 Health em 27					ltimore,M		21234
Pages 1			1 Rurial 2 Cremation 3 Removal from State cemetery, crea	matory or other place)		c. Location - City or T	
	coi	ì		neral Chapel Sept. 2. Name and Address of Facility	The second secon		
permit. Depertrimporte	once		TONCE TOUR DE	2. Name and Address of Facility Paceful Alternativ 325 York Rd. Timo	nium. Mar	vlano 210	on Ctr.,P.A. 093
			23a. Part. Enter the disease, or complications that caused the death. Do not enter shock, if heart failure, List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
Pnysici	_		Immediate Cause (Final disease or condition resulting in death)	ANCEL			Onset and Death
/Medic Examin	_		Due to (or as a consequence of):				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that mittated events c.				
ocuted nd transit		Examiner	Cause (Disease or injury that initiated events c.				
The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	L	al Ex	resulting in death) Last Due to (or as a consequence of):				
ficate ficate phys	=	edical	d				
leath certific attending p		lanyme	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2□Fetal death 3□	□Ectopic pregnancy		23d. Date of deliv	
the att		Pnysicia		Other (specify)		Month	Day Year
that the de ed by the detached	Č		Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacc	co use contribute to I	the cause of death?
w requires that is been signed I should be det		o D	Hypertension		1 Tes	aro 3□Pro	bably 4 Unknown
aw rec		piete			24a. Was an	24b. Were auto	opsy findings available
The late ha		Completed			autopsy performed 1 ☐ Yes 2 🔀	l? death?	ompletion of cause of 2□ No
slcian: The law certificate has birector, page 2 s		De	25. Was case referred to medical examiner?		(Check only one)		
Attending Physician: The I rector: After this certificate he by the funeral director, page	P	0	1 Inpatient 2 EH/Outpatier		me 3 Residence 28d. Describe how in	e 6 □Other (Special	fy)
nding th. r: Afte		arior	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending (Month, Day Year)	Work? M 1 ☐ Yes 2 ☐ No			
r Atte		Ceruncanon	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	t and Number or Run tate)	al Route Number,
urs affi	d						
To the Hospitel or Attending Physician: Within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.		Medical	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	n occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause ed at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
To the within To the		Me.	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day Year)
7			Same E Lynnon	m 01600	0 0	29/14/	05
V			30. Name and address of payrin who completed cause of death (Item 23) Type,	Frint) DS/AC DC	C. to 5	12 TOUS	on, Mi), 21204
	State	3	31. Date filed (Month, Day, Year) 32. Registrar's Signature		Juilos		1 1/2 5.50
	istra		SEP 2 0 2005 Beauto 15 April	9			

State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registrar 30490 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) September 19, Year 2005 920AM **Physician** Mary Laib /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Martin's Nursing Home Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 8 (Month, Day Year) 7. Age (In yrs. last birthday) 103 yrs 5. Social Security Number 217-26-4917 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 🕮 F Maryland Director Usual Residence of Decedent fited within 72 hours after death with the Maryland 10c. City. Town or Location 10b. County 10d. Inside City Limits 10a. State items 23s or 28a-f show 1 ☐ Yes 2 ☒ No Be Completed by Funeral Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 Maiden Choice Lane 21228 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) other treumatic event, the Modical Examiner: Black, White, etc. 1 ☐ Yes 2 No 1 □ Never Married 2 □ Married Specify:White Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: 3 ™ Widowed 4 □ Divorced neturel 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Book Keeper Wholesale 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James F. Rembold h and Mental Emma M. Huesing . Pages 1 and 2 should be iment of Health and Mentatent: If item 27 is marked 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances E. Place/Daughter 608 Upham Place NW Vienna Va 22180 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Loudon Park Cemetery 9-23-2005 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If eny injury or once. Baltimore, MD 1 4 ☐ Ponation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ambrose Funeral Home, Inc.
1326 Sulphur Spring Rd. Arbutus MD 21227 21. Signature of Funeral Service License 23a. Part . Enter the disea of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eumoni **Physician** disease or condition resulting in death) /Medical c Cardio Vascular Discasi **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the death certificate be executed use as the burial-transit Hyperten Dug to for as a consequence of) ertensio that initiated events resulting in death) Last Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a o 9□ Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records. 1 Yes 2 PNo 3 Probably 4 Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 1 Matural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide within 24 hours a To the Funerel C completely filled pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier September 19 2005 D 21649 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMBANDAM BASKARAN, 345T WILKENS AVE, BALTIMORE, MO21229 32. Registrar's Signature Andrew ! The second

Registrar

State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registrar 30491 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept **Physician** 18, 2005 4:00A M Roland Evans Langford /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5741 Edmondson Avenue Baltimore Catonsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, July 2, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Days Hours 1X M 2 ☐ F 1909 96 577-03-8246 Yrs. Maryland Director Usual Residence of Decedent the Maryland 10b. Counts 10c. City, Town or Location 10a State 10d. Inside City Limits 28a-f show 7 is marked other then "natural", or items 23a or 28a-f shoi treumetic event, the Madical Exemanar must be motified at 1 ☐ Yes 2 No Maryland Baltimore Catonsville Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5741 Edmondson Avenue 21228 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced "natural", 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "ne eny injury or other treumetic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Payroll Administrator Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Susan C. Foster Wn E. Ingersoll Langford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann L. Wagner, Daughter 11105 Potomac View Drive Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 09/22/05 Rose Hill Cemetery Hagerstown, Maryland ^ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee
Thomas Gregor 22. Name and Address of Facility
MacNabb Funeral Home, P.A.
301 Frederick Road Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final secural yx Pnysician Atheroscherotre andirasenler disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit 100 that initiated events signed by the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Cher (specify) be detached 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No s after death. investigation М 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year) 29c. License number September 19, 2005 127541 LEYON MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AGETMA RAJA MD 4367 HOUNK 10 Daltmone Rd tem 31. Date filed (Month, Day, Year) 32. egistrar's Signature State 0 2005 Registrar

			1 - For State of Maryland Registrar		artment of H			ene 2005	30492
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last) Leah P. Leavey			Location of Death	2. Date of Death Month Sept.		3. Time of Death
	Examin Funeral Director	er	4a. Facility Name (If not institution, give street and number) Hebrew Home of greater Was 5. Social Security Number 6. Sek 7. Age (In yrs. le 215-12-5252 1 M X F 88	hinglor ast birthday) Yrs.	Ro Clc If Under 1 Year Months Days	ville, V	8. Date of Birth (Month, Day, NOV. 25,	Montg	
	Maryland a-f show	tor	Usual Residence of Decedent	, Town or Lo	cation VILLE				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	n with the	al Direc	10e. Street and Number 6121 MONTROSE ROAD		10f. Zip Code	20852	10	g. Citizen of What	Country? USA
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant, I're Medical Examinar must be notified at Ance.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Was Decedent Ever in U.S Amed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:	ì	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🎇 No	ispanic Origin? (Spe in, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi Specify:	merican Indian,
Maryland 21215-0036	within 72 hou lene. Then "nature the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give lite. L	dent's Usual Occupi kind of work done of DO NOT use retired ETARY	during most of working	ng	6b. Kind of Busines	,
/land 2	should be filed and Mental Hyg s marked other umatic evant,	To Be C	17. Father's Name (First, Middle, Last) MORRIS	PATS		18. Mother's Name			SNYDER
	und 2 sho alth and i 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) MARC LEAVEY / SON	1		and Number or Rural - BALTIMO			a, Zip Code)
nore,	ages 1 a out of Hei t; If itam y or othe	0.00	1 X Burial 2 Cremation 3 Removal from State	emetery, cren	sition (Name of matory or other place			Oc. Location - City o	
Baltimore,	permit. P Departme Importan any injuri once.		21. Signature Funeral Service Licensee	22	. Name and Addres	ss of Facility SOL	LEVINS	ON & BROS	
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rds, P.	w requires that been signed t should be det	þ	Part II. Other significant conditions contributing to death but not resu Sacral Pressure wice	Iting in the ur	nderlying cause give	en in Part I.	23e. Did toba	,	to the cause of death? Probably 4 □Unknown
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Division of Vital	To the Hospital or Attanding Physician: The I within 24 hours after death. To tha Funaral Director: After this certificate he completely filled in by the funeral director, page	ation; To Be	27. Manner of Death 1 PNatural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injun Work	4 W Nursing Hom		nce 6 ⊡Other (Sp	pecify)
Divis	To the Hospital or Attanding within 24 hours after death. To tha Funaral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At hor building, etc. (Specify,	ne, farm, stre	eet, factory, office	2	8f. Location (Stre City or Town,		Rural Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical (29a. Certifier (Check only one) 1. Certifying Physicien: To the best of my know 2 Medicel Exeminer: On the basis of examinati and manner stated.						
	within To the comp	Ž	29b. Signature and title of certifier		29c. License	37464	5 S	d. Date signed (Mo.	nth, Day, Year)
	1		30. Name and address of person who completed cause of death (Item	23a) (Type, I	Print)	d Roda	ille.	w 2	0852
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2, 0, 2005 32. Registrar's Signati	ure	Locale	d Roila	1		

			1 - For State Registrar	State of Ma	aryland / Dep	artment of rtificate of		Mental Hyg	giene neg. n2 0 0 5	30493
	Physic	ian	Decedent's Name (First, Middle, Last)	BARRY	ERIC MAJI	EROWICZ		2. Date of Dea		3. Time of Death 9:15 PM
	/Medi Examir		4a. Facility Name (If not institution, give s 125 Fort Hoyle			4b. City, Town, Joppat	or Location of Dea		4c. County of Dea	
Ī	Funeral Director		5. Social Security Number 6. Sex 213-90-0151	7. Age M 2□ F	(In yrs. last birthday,		If Under 24 Hr		y Year) 9. Bir	thplace (State or Foreign ountry)
	uyland show		Usual Residence of Decedent 10a. State 10b. County Maryland N/A		10c. City, Town or L		imore			10d. Inside City Limits
	ith the Ma or 28a-f	Director	10e. Street and Number	Letitia	Avenue	10f. Zip Code	21230		10g. Citizen of What C	1 XYes 2 No ountry?
"	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Evantrat must be routilled at	Funeral		2. Was Decedent E Armed Forces? 1 ☐ Yes 2 🕱 N	Ever in U.S. 13.	If Yes, specify Cui	Hispanic Origin? (pan, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	USA 14. Race - Am Black, Whi	
5-0036	'2 hours a natural', o ical Eyar	þ	3 Widowed 4 Divorced 15. Decedent's Educ		16a. Dece	1 Yes 2 No	pation	orking	Specify: V	White Windustry
Maryland 21215-0036	filed within 7 Hygiene. other than "n ent, the Med	Completed	(Specify only highest grade	College (1-4or 5-	+) life.	rvice Tec	ed)		Hewlett Pa	ickard Co.
/land	2 should be filed and Mental Hygic is marked other aumatic event, I	To Be (17. Father's Name (First, Middle, Last)	Gilbert	Majerowic	Z		ence Bud		
	1 and 2 sho Health and I tem 27 is me		19a. Informant's Name/Relationship (Ty) Deborah A. Frank	oe, Print) (Siste	er) 1 S	tephen La		Rural Route Number nam, Massa	r, City or Town, State, achusetts	Zip Code) 02.026
Baltimore,	Pages 1. nent of He ant: If Iten ury or oth		20a. Method of Disposition 1 園Burial 2 □ Cremation 3 □R 1 □ Donation 5 □ Other (Specify)	amoval from State	20b. Place of Disponentery, cre Glen Hav	matory or other pla	(9/1		20c. Location - City or Glen Burnie	Town, State e, Maryland
Balt	permit. Pages Department of Important: If It any injury or once		21. Signature of Funeral Service Linense	∘ Kevin E	Ecker M	2. Name and Addr CCuII.y=Po 204 Moun	ess of Facility Diyniak I tain Rd.	Funeral Ho , Pasadena	ome P.A.	21122
A. Company	Physician /Medical		23a. Fart1. Enter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each lin	е.	ter the mode of dy	ing, such as cardi	ac or respiratory arr	est,	Approximate Interval Between Onset and Death
8760,	rate be executed thysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequence of):					
O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	ic. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	2 Fetal death 3	Ectopic pregnand Other (specify)	;y		23d. Date of de Month	livery Day Year
0	quires that in signed by	b	Part II. Other significant conditions con	ributing to death bu	t not resulting in the u	nderlying cause gi	ven in Part I.	23e. Did tob	bacco use contribute to	o the cause of death?
Vital Records,		Completed						24a. Was a autops perform	y prior to	utopsy findings available completion of cause of
of Vita	Physician: Th this certificate ral director, pag	To Be	1 Tes 22 No	ospital:		IL JE DOX	her: 4 Nursing	Home 5 Reside	ence 6 XOther (Spe	Friend's
Division	ing After une	Certification:	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day		M 1	ny at ork?]Yes 2 ☐ No		ow injury occurred	
Divi	in State		4 Homicide determined	building, etc.				City or Town		
	To the Hospital within 24 hours a To the Funeral Completely filled	ledical	(Check only 2 Medicel Exemin	er: On the best of and manner stat	examination and/or in	vestigation, in my	opinion, death occ	curred at the time, da	ause(s) and manner as ate and place, and due	to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier			29c. Licen	5130/	2:	9d. Date signed (Mont.	n, Day, Year) 2005
_	8		30. Name and address of person who con	npleted cause of de	ath (Item 23a) (Type,	Print) Stynte	PJ.	#300	Annyoli	5 MO2149
•	Sta Registr	- 1	31. Date filed (Month, Day, Year) SEP 2 0 200	32. pegistra	r's Signature	and I			/	

			, rot	artment of Health and Mental Hy ertificate of Death	giene 005 30494
	Physici /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> SHIRLEY MAE McCAUSEY	2. Date of De SEPTEM	
	Examin		4a. Facility Name (If not institution, give street and number) 2402 229th Street	4b. City, Town, or Location of Death Pasadena	Anne Arundel Co.
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 59 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Bir Nov . 05	th 1945 9. Birthplace (State or Foreign Country) Maryland
	show	'n	Usual Residence of Decedent 10a. State	ocation dena	10d. Inside City Limits 1 ∐Yes 2 🛣 No
	with the N e or 28e-f the notifii	Director	10e. Street and Number 2402 229th Street	10f. Zip Code 21122	10g. Citizen of What Country?
36	be filed within 72 hours after death with the Maryland tal Hygiene. od other than "netural", or Items 23e or 28e-1 show event, the Medical Exaft are finial be notified at	by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give A	Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:	14. Race - American Indian, Black, White, etc. Specify: white
Baltimore, Maryland 21215-0036	within 72 hour ene. then "netural"	Completed b	15. Decedent's Education (Specify only highest grade completed) [Specify only highest grade completed] [Give [1-40r 5+]	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) emaker	16b. Kind of Business/Industry Home
and 5.	ould be filed w Mental Hygie arked other t atic event, In	To Be Co	17. Father's Name (First, Middle, Last) Daniel W. Aims	18. Mother's Name (First, Middle Lillie V.	, Maiden Sumame)
Mary	and and sm	ř	19a. Informant's Name/Relationship (Type, Print) Kelly McCausey (Daughter) 240	ing Address (Street and Number or Rural Route Numb 2 229th Street, Pasadena,	er, City or Town, State, Zip Code) Md • 21122
imore,	Pages 1 and 3 nent of Health snt: If Item 27 ury or other tr.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify)	ematory or other place)	20c. Location - City or Town, State Baltimore, Md.
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Fun at I Service Licensee	^{22. NarMcCdTTY^oP6Tyniak Funer 237 E. Patapsco Ave. E}	
8760,	truy sician and hysician and physician and true pariar-transit true beriar-transit true beriar true be	dicai Examiner	23a. P.A.1. Enter the disease, or complications that caused the death. Do not en Shock, or heart failure. List only one cause on each line. Intriediate Cause (Final isease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	REAST CANTER	rrest, Approximate Interval Between Onset and Death
O. Box 68	death certifii e attending f id for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
rds, P.	es the	by	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I. 23e. Did t	obacco use contribute to the cause of death? Yes 2 XNo 3 ☐ Probably 4 ☐Unknown
Vital Record	The law ate has b page 2 sl	Completed		24a. Was auto perfo 1 □ Yes	
Division of Vita	or Attending Phyaician: Thater death. Director: Atter this certificate in by the funeral director, pag	ertification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 28a. Date of Injury (Month, Day Year) Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28c. Place of Injury - At home, farm, st building, etc. (Specify)	of 28c. Injury at Work? M 1 Yes 2 No	dence 6 Other (Specify) how injury occurred Street and Number or Rural Route Number,
۵	Hospital or 4 hours aft Funeral Di ely filled in	edical Cer	29a. Certifier Check only Ch	th occurred at the time, date and place, and due to the	cause(s) and manner as stated
·	To the h within 24 To the F complete	Med	29b Signature and title of detifier	29c. License number	29d. Date signed (Month, Day, Year)
	3		30 Name and address of person the completed capts of death (Item 23a) (Type	Print) CATON AVENUE P	DEPTEMBER 19, 2005 DANTIMORE, MDD1009
\$4	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 0 2005 SEP 2 0 2005	all)

			1 - For State Registrar	State of Maryla	and / Dep <i>Ce</i>	artmen ertificate	t of He e <i>of D</i>	alth and	d Mental H	ygiene Reg. No.	005	30495
	Physici	an	Decedent's Name (First, Middle, Last,	- 1					2. Date of I Month	Day	/ Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give	Mc Elroy		4b. City.	Town, or L	ocation of D	eath 9	4c.	County of Death	
	Exami	er		buy view. Medi	cal Cont		Itimo				altimor	
	Funeral		5. Social Security Number 6. Se	7. Age (In yi	s. last birthday			if Under 24 h			9. Birth	place (State or Foreign intry)
	Director		215-46-7470 16 Usual Residence of Decedent	3M 2LJF	57 Yrs.				9/	25/4		RYLAND
	land		10a, State 10b, County	10c.	City, Town or L	_ocation						10d. Inside City Limits
	Mary a-f eh	tor	MARYLAND N/A		BALT	IMORE					ĺ	1X Yes 2 No
	or 28s	lrec	10e. Street and Number	<u> </u>		10f. Zip	Code			10g. Citiz	zen of What Cou	intry?
	death with the Maryland ime 23e or 28a-f ehow	ral	4836 BOWLAND AVE				2120				.S.A.	
	after des or iteme	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No	U.S. 13	. Was Deced If Yes, spec	ent of Hisp ify Cuban,	panic Origin? Mexican, Pu	(Specify Yes or It lerto Rican, etc.)	10-	4. Race - Ameri Black, White	
936	urs aff	ρ	3 ☐ Widowed 4 🋣 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	2⊠ No	Specity:			Specify: BLA	CK
Maryland 21215-0036	be filed within 72 hours after death with the Marylar ital Hyglene. ed other than "natural", or iteme 23e or 28e-f show event, the Medical Examinat must be natified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dec	edent's Usua e kind of wor	l Occupati	on ring most of	workina	16b. Kir	nd of Business/Ir	ndustry
2	within ene. then	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT us	e retired)					
2	e filed within al Hyglene. I other then '		12th grade 17. Father's Name (First, Middle, Last)	l yr	DES	IGNER/			Name (First, Midd		STRUCTI(Surname)	ON
an	Mental arked o	To Be	JOSEPH ARMSTRON	IG.					A PRESTO			
ary	should be and Mental marked o	F	19a. Informant's Name/Relationship (T)		19b. Mai	ling Address	(Street an		Rural Route Num		Town, State, Zi	o Code)
Σ	s 1 and 2 if Health a ltem 27 ie other trai		Roy K. Armstrong/					., Bal	timore,			
ore	Pages 1 nent of He int: If Iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ F		. Place of Disp cemetery, cre			1	Date	20c. Loc	cation - City or T	own, State
Baltimore,			*4 □Donation 5 □Other (Specify) 21. Signature of Fund Sweet License	~ ///	ETRO CR			1	-22-05	BAL	TIMORE,	MARYLAND
Bal	permit. Department importations and injury i		21. Signature of Punets San August	Deower	W	22. Name and ILLIAM 206 W	I C BI	ROWN C	OMMUNITY UE	FUNE	RAL HOM	E P.A.
			23a. Part1. Boter the disease, or compleshock, or heart failure. List only of	ications that caused the de ne cause on each line.				such as card	fiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Biliary	Obst	ruct	non					one month
	Examiner		Sequentially list conditions	Due to (or as a cons). Due to (or as a cons)	adder	Ca	nce	<u></u>				4 months
V	cuted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c.	equence or).							
8760,	ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or as a cons	equence of):							
687	tificate ng phys as the	edlc		1.								
Вох	ndir use	an/M	23b. was decedent pregnant	3c. If yes, outcome of preg		□Ectopic pre	gnancy			2	3d. Date of deliv	
		Physiclan/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of 9☐Unknown	death 5	Other (spe	ecity)				Month	Day Year
s, P.O.	The law requires that the sie has been signed by th page 2 should be detache	by Ph	Part II. Other significant conditions con	ntributing to death but not re	esulting in the	underlying ca	iuse given	in Part I.	23e. Díd	tobacco us	se contribute to t	he cause of death?
Records,	w require	ted							_ 1[Yes 2]No 3∏Prol	oably 4 ⊒thknown
Sec.	elawi hasbo je 2 sh	Completed							24a. Wa	s an opsy formed?	24b. Were auto prior to co death?	ppsy findings available impletion of cause of
									1 ☐ Yes	2☑No		2□ No
Vital	sicial certifirecto	o Be	25. Was case referred to medical examiner?	lospital: 1 Inpatient 2	☐ ER/Outpatie	ent 3 DD	Other		Death <i>(Check only</i> ☐ Home 5 ☐ Res		Other (Special	6.1
1 of	Attending Physician: The r death. ector: After this certificate hiby the funeral director, page	n: To	27. Many of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		Bc. Injury a Work?		28d. Describe			y)
io	anding lath. pr: After	atio	1 Natural 5 Pending investigation	(World), Day Youry	injury	М		s 2□No				
á	of the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, si cify)	treet, factory,	office		28f. Location City or To	(Street and own, State)	Number or Rura	al Route Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Exami	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, dea nation and/or in	th occurred a nvestigation,	at the time, in my opin	date and pla ion, death or	ice, and due to the courred at the time	cause(s) a , date and p	and manner as s place, and due to	tated. o the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	1			License n			29d. Date	signed (Month,	Day, Year)
7			Janet Rea	nd MD		A	Fall	04200	-R370	9/	17/00	5
	1		30. Name and address of person who co	D lis			11		· · · · ·	-		
		•	31. Date filed (Month, Day, Year)	32. Apgistrar's Sig		413a	4					
	Sta Registr		SEP 2 0 201	ALC:	K A	reels?						

			1- State of Maryland / Department of Healt Certificate of Dea	th and Mental I ath	Hygiene 00	5 30496
1		ė l	Decedent's Name (First, Middle, Last)	2. Date of Month	f Death	3. Time of Death
1	Physici /Medio		John, Myszka	Sept	F. 8 2	2005 21:11 PM
	Examir		4a. Facility Name (If not institution, give street and number) Hospital Columbia	a, MD	4c. County of	d County
76	Funeral Director		058-14-5922 1 X M 2□ F 87 Yrs. Months Days Hou	urs Min. 8. Date of SEPT.	f Birth , Pay, Year) 12, 1917	Birthplace (State or Foreign Country) NEW YORK
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Marylan -f ehow find at	tor	MD ANNE ARUNDEL LAUREL			1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of W	hat Country?
	th wit		326 VALE SUMMIT SOUTH 20724		USA	
21215-0036	72 hours after death with the Maryland "natural", or iteme 23a or 28a-1 ehow solical Exeminations be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic If Yes, Specify Cuban, Mex Off Yes, Give Year or Dates:	xican, Puerto Rican, etc.		- American Indian, , White, etc. WHITE
2-0	72 ho	sted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during i	most of working	16b. Kind of Bus	iness/industry
121	be filed within 72 ho tal Hygiene d other then "natur event, tre Medical	Completed	Elementary/Secondary (0-12) 12 College (1-4or 5+) Ø OPERATING ENGINEER	most of troming	GOVERN	MENT
20	a filed val Hygie other t		-	Mother's Name (First, Mid		
lan	2 g 2 5	To Be		OUISE BUCKI		
Maryland	and and	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nu			·
	s 1 and 2 f Health item 27 I		MARGARET REITZEL / DAUGHTER 3283 SUDLERSVILLE : 20a. Method of Disposition 20b. Place of Disposition (Name of	SOUTH, LAUREL,		724 Lity or Town, Slate
Baltimore,	permit. Pages Department of the important: If ite any injury or of once.		1 🖸 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD VETERANS CEMETERY	9/13/2005		LE, MARYLAND
Ħ	permit. P Departme Importan eny injury once.		21. Signature of Fun ral Service Licensee / 22. Name and Address of Fa		NERAL HOME, I	
ñ	Depa impo eny ir		Moma War 7601 SANDY SPR	ING ROAD, LAUR	REL, MARYLAND	20707
8,4	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, of weart failure. List only one cause on each line. Immediate Cause (Final disease or condition		ry arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):			
*		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. CORONALY ARTCA- Due to (or as a consequence of):	1 DISGAS	(-	
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events			
ó,	cate be executed bhysicien and the burial-transii		resulting in death) Last Due to (or as a consequence of):			
8760,	icate be executed physicien and s the burial-transit	dical	d			
9 x c	death certifica e attending pl ed for use as t	√Me.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date	of delivery
О. Вох	0 0 0	Physician/Me	n the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Monti	,
ds, P	8 69	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa			ute to the cause of death?
COL	- U 0	iete	2. HO HTPGZTENSION.	24a. W	•	
	The law sete hes b page 2 sl	Completed	7 (0 4) (1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	au	erformed? de:	ere autopsy findings available or to completion of cause of ath? Yes 2 \sum No
Vita	Physicien: The this certificete	Be	exampler?	lace of Death (Check on		
	Z 20	1: To	1 Inpatient 2 EH/Outpatient 3 DOA 4	Nursing Home 5 R	esidence 6 Other be how injury occurred	
ion	Attending r death. ector: After by the fune	ation	27. Manner of Death 1 NaNatural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 38c. Injury at Work? 1 Yes 2			
É	al or Attend after death I Director: / d in by the f	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or	n (Street and Number Town, State)	or Rural Route Number,
	Hospita 4 hours Funere ely fille	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, and manner stated.	e and place, and due to to death occurred at the time	he cause(s) and mann ne, date and place, and	ner as stated. d due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (
			Mulfal m.D. Doog	2735	Sep 8	, 2005
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A 20 rn 2 J0 nn 2 m . 7 . 143 W.	2735 Montgom	eru St.	Balhmore,
9	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature)	21230
	Registr	_	SEP 2 0 2005 March 1 Amelia			2.250

Division of Vital Records, P.O. Box 68760.

JOHN MANNING

		State Registrar			Certific	cate of	Death	1.5. 1.	Reg. N	2000	30497
sicia edic		 Decedent's Name (First, Middle, L John H. Manning 	ast)					2. Date of I Month Sept	D	ay Year • 2005	3. Time of Death
min	_	4a. Facility Name (If not institution, gr Stella Maris Hos			4b.	City, Town, o		f Death	4	c. County of Death Baltimo	
al	e4 .		Sex 7. Age	(In yrs. last I		Under 1 Year	If Under 2		Birth	9. Birth	nplace (State or Forei
or		5. Social Security Number 215-82-0666	1X M 2□F 4	+7 	Yrs. Mo	nths Days	Hours	Min. (Month, i	Day, rea	1 -	untry) Maryland
		Usual Residence of Decedent 10a. State 10b. County		, .	own or Location						10d. Inside City Limi
	ctor	Maryland Baltin	nore	L.	ansdowi	ne 			,		1 □ Yes 2X N
	I Director	10e. Street and Number 155 Howard Ave.			10	of. Zip Code 212	227		10g. C	U. S. A.	
	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. Was I	Decedent of H	lispanic Orig	gin? (Specify Yes or I Puerto Rican, etc.)	No-	14. Race - Amer Black, White	
	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 24 No If Yes, Give Year or Dates:)	1 🗆 Y	res 💥 No	Specify:			Specify: V	Vhite
	eted	15. Decedent's 8 (Specify only highest g	Education rade completed)	16	6a. Decedent's (Give kind	of work done	during most	of working	16b.	Kind of Business/l	Industry
	Completed	Elementary/Secondary (0-12)	College (1-4or 5+))	Carper	iot use retired nter	1)			Construct	ion
	Be Co	17. Father's Name (First, Middle, Las	st)				18. Mothe	r's Name (First, Midd	lle, Maide	en Sumame)	
	To	Howard W. Mannin						yle Powna			
		19a. Informant's Name/Relationship		15	_			r or Rural Route Num			(ip Code)
1		Gayle Jarbo, mot	-ner	20b. Place	of Disposition	oward A		Lansdowne :		21227 Location - City or	Town, State
1		1 ☐ Burial 2 ☐XCremation 3 4 ☐ Donation 5 ☐ Other (Spec			iew Cre			09-22-05	Bal	ltimore,	MD
ĺ		21. Signature of Funeral Service Lice	ensee		22. Nar Amb 1	me and Addre	ss of Facility	Home of I	ansc	lowne	
		resulting in death)	Due to (or as a	CORSEQUENC		ER					
38	Examiner	Sequentially list conditions, I any leading to in nediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cue to (ar as a compared to	Consequenc	ad offic						
		If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	c	consequence f pregnancy	ce of):	opic pregnancy				23d. Date of deli Month	ivery Day Year
	Physician/Medical	Life Type of the property of t	c. Due to (or as a d. 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at till 9 Unknown	consequence f pregnancy Fetal dea	ce of): ath 3 Ecto 5 Oth	opic pregnancy er (specify)		23e. Die	d tobaccc	Month	Day Year
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State of Maryland / Department of Health and Mental Hygiene Reg. 2.005 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 6:15 PM September 16, 2005 Robert Lyle Miller /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 608 Wilson Avenue Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**∑**M 2□F Months 232-22-8234 85 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No N/A Baltimore Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 608 Wilson Avenue 21224 USA Items 23e Funera 12. Was Decedent Ever in U.S. Armed Forces? 1942 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after d Department of Heelth end Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Event 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ð Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Welder Boating 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Arthur Britton Miller Emma Lee Wolf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melinda Lea Gower, Niece Rt1. Box 52-H-1 Lost Creek, West Virginia 26385 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 09/19/05 * 4 □Donation 5 □ Other (Specify) Metro Crematory Inc. Baltimore, Maryland 21. Signatury of Funeral Service of ense Thomas Gregor ^{22. Name and Address of Facility} Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Prostate disease or condition resulting in death) Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine physicien and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Box 68760 Due to (or as a consequence of): Physician/Medical as attending p JE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 1 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has by page 2 s certificate 1 Yes 2 No Division of Vital To the Hospital or Attending Physiclen: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: ٢ 1 ☐ Yes 2 No 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours aft.

To the Funerel DI

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Saranya Chumsri, Mo. 9/19/05 13-11545 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene Baltimore MD Stypet 31. Date filed (Month, Day, Year) 32. Degistrar's Signature SEP 2 0 2005 Registrar

AMENDED BY COURT UNDER Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 1.17 per co 2949 3-12-14 vt. Mental Hygiene 05 30499 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time ol Death Month Year **Physician** Nancy William Marvelis AKA Nafsika Marvelis 2005 September 16 7:40P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County General Hospital Westminster Carrol1 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 3,1907 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** MARVEUS 1 M 2 □ F 559-28-4369 98 Director Greece Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f shoy ortant: If itam 27 is marked other than "natural", or Itams 23a or 28a-f shov injury or other traumatic avant, the Medical Examinational De notified at 1 ☐ Yes 2 No Director Marvland Howard Woodstock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1921 Covewood Lane 21163 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 15 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2K No Specify: Specify: 3X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Haralambos Cominos AKA Be 2 should be f and Mental } Robert Cominos Haralambos Comninos Peristerra Paxinos 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other trau Gus W. Marvelis 1921 Covewood Lane Woodstock, Maryland 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greek Orthodax Cem. 9-20-2005 Woodlawn, Maryland 21. Signature of Funeral Sepace Licensee 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave. Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Holvanced **Physician** /Medical Due to (or as a consequence of): Examiner 4SP has Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o as a c sequence of). Examiner certificate be executed VVVIIIe Box 68760. Due to (or as a consequence of): attending physician Physiclan/Medlcal o huic the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 4☐Pregnant at time of death P.0. ihe 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by 1 Yes 2 No 3 Probably 4 Unknown Completed Vascular Ischem 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an certificate 2 No 1 Yes 1 Yes 2 No o tha Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 Thipatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Matural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ within 24 hours after To the Funaral Dirac 4 - Homicide 1 Destrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

DHMH 17 Rev 1/200

29b. Signature and title of cepifier

31. Date filed (Month, Day, Year)

RAMAN

SEP 2 0 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B. Kanera

32. Registrar's Signature

29c. License number

349 Malcely drive

-0054218

29d, Date signed (Month, Day, Year)

21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 30500 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** MOTTIS 2:35 AM L. 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Oeath Examiner university of maryland medical Center Baltimor If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1 M 2 X 08-08-1936 629-42-8490 Director Liberia Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Moutcal Examinar is ust be notified at Camp Springs MD Prince George 11 Yes 2 No Funeral Director 10e. Street and Number 5163 B Walmsley Court 10g. Citizen of What Country? 10f. Zip Code 20762 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If Itam 27 Is marked other than "natural; or Ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3₺Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Teacher Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Jdk Baker Margurite Klade 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Junda W. Morris/ Daughter 5163B Walmsley Ct., Camp Springs, MD 20762 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Daurial 2 Cremation 3 Removal from State injury or permit. Page Department of Important: If any injury or once. Resurrection Cem. 09-24-05 Clinton, MD ` 4 ☐ Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Taylor's Funeral Home 1722 North Capitol St. NW Wash. DC 20002 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gastrointestin **Physician** hour disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: use 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No
9 Unknown Day Month Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Carrer 2X No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No Ovarian 24a Was an autopsy performed? ascites Yes Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred Injury at Work? 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 16643 Less, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) brunifer C. Desimb-22 Swith Greens Street, Bookimore maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 0 2005 Registrar